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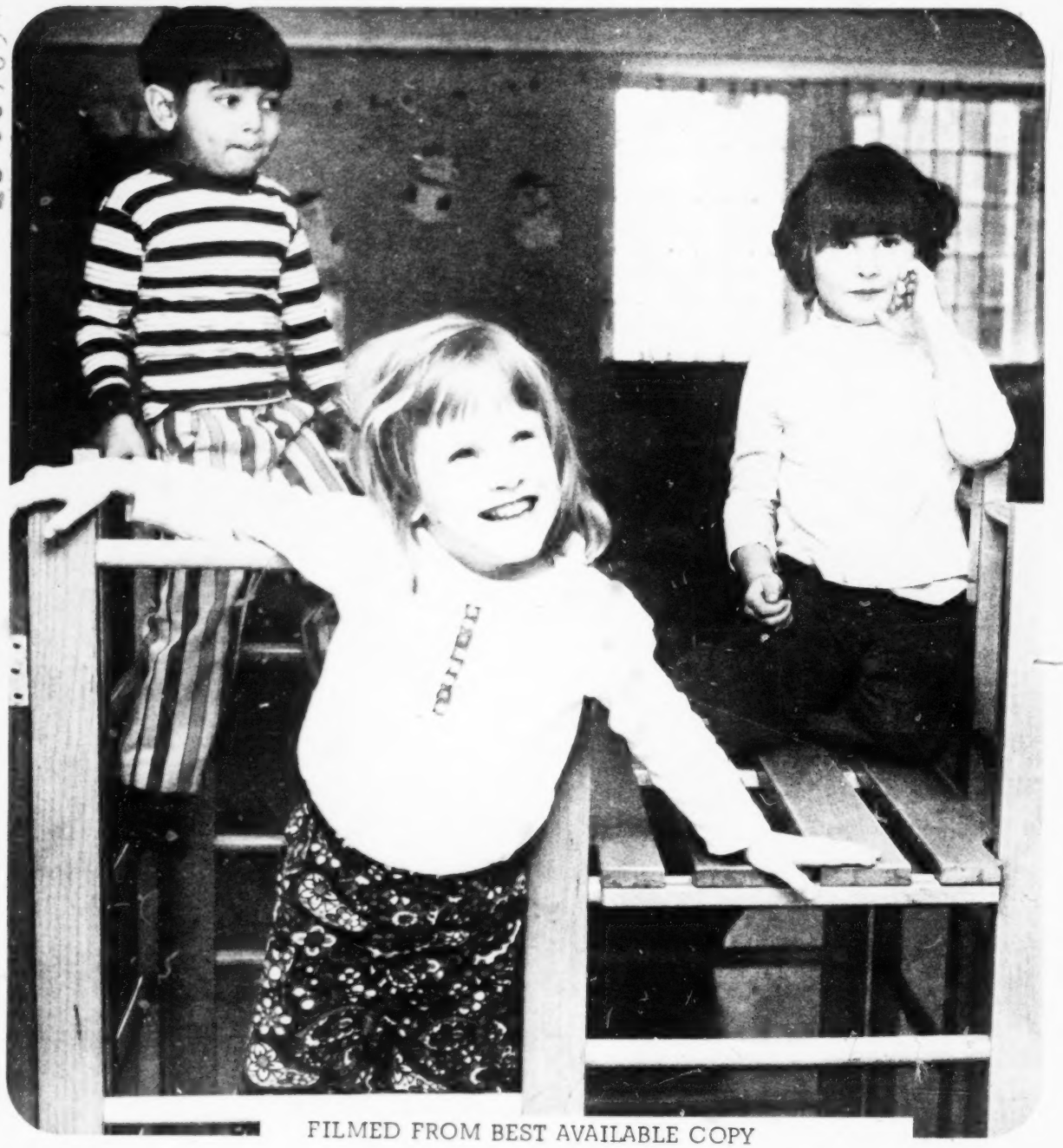
ABSTRACT

Examined is a 2 year program in which itinerant teachers provided preparatory educational experiences to preschool visually handicapped children and demonstrated specific educational techniques to parents. Explained are: procedures of identification, referral, interviewing and instruction; use of paraprofessionals, mobility specialists, and student teachers; and the development of a toy library where entries were catalogued according to age levels and developmental goals. Children are identified according to diagnosis, age at time of report, number of itinerant teacher visits, disposition, and cooperating agency. Six case studies which include reports of mobility students, instructional aides, or nursery school teachers are presented. (GW)

A Model For Preschool Educational Services For Handicapped Children

ED 069059



EC 050 117

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Allegheny Intermediate Unit No. 3
Exceptional Children's Program
Pittsburgh, Pennsylvania
1972

COVER PHOTO:

Randi-Jane, 4, in foreground, plays on the climbing bars in a church nursery school. Randi, blind since birth, was integrated into the nursery school program through the services of the Allegheny County program for preschool visually handicapped.

ALLEGHENY INTERMEDIATE UNIT

HAROLD E. OYER · EXECUTIVE DIRECTOR
B. F. Jones Annex · 311 Ross Street · Pittsburgh, Pa. 15219
(Area Code 412) 355-4301

ENCLOSED IS A COPY OF THE REPORT OF THE FEDERALLY FUNDED PROJECT CONDUCTED BY THE ALLEGHENY INTERMEDIATE UNIT FOR THE TITLE VI-A, E.S.E.A. PROJECT #48-0203-02-012 FOR PRE-SCHOOL VISUALLY HANDICAPPED CHILDREN.

I THINK YOU WILL FIND IT AN INTERESTING ACCOUNT OF ONE OF THE WAYS WHICH THE EXCEPTIONAL CHILDREN'S PROGRAM IS SERVING HANDICAPPED CHILDREN.

IF YOU SHOULD HAVE ANY QUESTIONS REGARDING THIS PROGRAM, PLEASE FEEL FREE TO COMMUNICATE WITH ME AT 325-1132.

SINCERELY YOURS,

Gayle Park

GAYLE PARK, DIRECTOR
TITLE VI-A, E.S.E.A.

GFC
ENCL.

ED 069059

A PLAN FOR ITINERANT EDUCATIONAL CONSULTANT SERVICES FOR PRESCHOOL VISUALLY HANDICAPPED CHILDREN

Conducted By:

Allegheny Intermediate Unit No. 3
Exceptional Children's Program
Pittsburgh, Pennsylvania

Pennsylvania Department of Education

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Chapter I

INTRODUCTION

In recent years it is becoming increasingly apparent that all special educators must address themselves to education of handicapped children at the "preschool," or "preacademic" level. Historically, the schools have bowed to the magic age of six as the time for formal educational intervention into the development of children, on the premise that children before this age will develop incidentally those skills necessary for academic learning. Research and experience with handicapped children has proven this premise to be invalid. There are early learning experiences encountered by normal children which are not available to blind and physically handicapped children because of their limited ability to move freely in space; deaf children do not develop adequate concepts until language is established; and children who are slow in development may not learn appropriate skills from their environmental experiences without intervention. Some children are overprotected, some are institutionalized shortly after birth, and some are not motivated to develop skills which they are capable of learning.

In 1969, the Allegheny County Schools (now the Allegheny Intermediate Unit No. 3), Exceptional Children's Program, demonstrated its concern for very young handicapped children, by conducting a survey of private agencies in Allegheny County to determine the areas of the needs of preschool handicapped children. At the suggestion of the administrator of the Pittsburgh Branch of the Pennsylvania Association for the Blind, it was decided to focus on visually handicapped children. In cooperation with the Pennsylvania Department of Education under Title VI-A of the E.S.E.A., a "Demonstration Project on Developing Independence in Preschool Visually Handicapped Children" was conducted during the summer of 1969. Seven multiply handicapped, visually handicapped children, aged three through six years, attended a preschool class for six weeks. The children were instructed in skills of daily living and orientation and mobility skills directed toward the development of personal independence. The instruction was predominantly individual, but some group experiences were provided.

An important component of the demonstration project was that of parent education. Each week a resource person met with the parents to discuss problems and to instruct the parents in the methods by which they could continue the educational training at home. Mrs. Martha Goldberg, Executive Director of the Pittsburgh branch of the Pennsylvania Association for the Blind, discussed from a social case work orientation, the effect upon children of attitudes of parents. Dr. David M. Hiles, Pediatric Ophthalmologist, discussed the medical management of eye diseases. Dr. Ralph L. Peabody, Professor, Department of Special Education and Rehabilitation, University of Pittsburgh, discussed specific educational techniques to be used with visually handicapped children. Miss Pauline M. Moor, Program Specialist in Education, American Foundation for the Blind, discussed the growth and development of multiply handicapped visually handicapped children. Miss Elinor Long, Supervisor Programs for the Visually Handicapped, Bureau of Special Education, Department of Education, Pennsylvania, discussed planning at the state level for educational programs for multiply handicapped children, and Dr. James F. Jordan, Assistant Superintendent, Allegheny County Schools, discussed planning at the county level. Medical social workers from the Pittsburgh branch, Pennsylvania Association for the Blind, and caseworkers from child service agencies attended each parent session and served as interpreters and counselors to parents. Follow-up on the children demonstrated that the change in attitudes and aspirations, and the knowledge of instructional techniques of the parents, enabled the children not only to retain the gains, but to progress during the year.

During the summer of 1970, the project was again conducted with Title VI-A, E.S.E.A. funding. Some changes were made, the most important being the addition of a strong language-development component. Again the children demonstrated gains. Follow-up revealed that six of the seven children were able to be accepted into existing public and private educational programs during the following year.

These two programs clearly demonstrated the value and indeed the necessity for early training of handicapped children. They also clearly demonstrated the value of training of parents in the educational techniques which could enhance the development of their children.

These results led the Allegheny Intermediate Unit, Exceptional Children's Program, into creating the "Plan for Itinerant Educational Consultant Services for Preschool Visually Handicapped Children," which was conducted in cooperation with the Pennsylvania Department of Education under Title VI-A, E.S.E.A. The objectives of the plan were to provide parents with

knowledge of and demonstration of specific educational techniques, to foster the learning of specific tasks before the child reached school age, and to provide direct service to the children. The plan was devised to extend the reach of the itinerant teacher and the educational programs for the children, by the parents, and para-professional's training by the teacher. An additional objective was to foster close cooperation between the social worker, medical personnel, and the educational specialist. The program was extremely successful during the first year and was continued during the school year 1971-72.

This report presents the results of the two-year itinerant plan. We encourage the reader to consider this plan as a model after which programs may be planned for the education of not only visually handicapped children, but children with other disabilities for whom formal classroom programs may not be possible.

Chapter II

PERSONNEL

Allegheny Intermediate Unit No. 3

Dr. Edward P. Cibik, Jr., Director of Special Education
Exceptional Children's Program

Mrs. Gloria Gayle Park, Teacher-Director
Title VI-A Project

Aides:
Mrs. Barbara Brown
Mrs. Marguerite Norton
Mrs. Carmen Levy
Mrs. Eileen Piepgrass

Consultant

Dr. Mary W. Moore
Department of Special Education & Rehabilitation
Education for the Visually Handicapped
University of Pittsburgh

Steering Committee

Chairman:
Dr. Ralph L. Peabody, Coordinator
Program for the Visually Handicapped
Department of Special Education & Rehabilitation
University of Pittsburgh
Pittsburgh, Pennsylvania 15213

Miss Margaret F. Gnade, Director of Welfare Services
Pittsburgh Branch, Pennsylvania Association for the Blind
308 S. Craig Street
Pittsburgh, Pennsylvania 15213

Steering Committee (Contd.)

Charles H. Bisdee, Executive Director
Home for Crippled Children
1426 Denniston Avenue
Pittsburgh, Pennsylvania 15217

Elizabeth C. Harmuth, L.P.T., Director
Easter Seal Services
14 Wood Street
Pittsburgh, Pennsylvania 15222

Miss Mary Lou Ende, M.S., Nurse Specialist
Developmental Clinic of Children's Hospital
125 DeSoto Street
Pittsburgh, Pennsylvania 15213

Miss Barbara Fallet, Director Preschool Program
Pennsylvania Association for Retarded Children
917 Brighton Road
Pittsburgh, Pennsylvania 15233

Dr. Janet Kleinman, Director--Lower School
Western Pennsylvania School for Blind Children
Bayard at Bellefield Streets
Pittsburgh, Pennsylvania 15213

Sister Helen Santay
Diocese of Pittsburgh Child Center
Department of Special Education
162 Steuben Street
Pittsburgh, Pennsylvania 15220

Ex Officio Members:

Dr. Edward P. Cibik, Jr., Director of Special Education
Exceptional Children's Program
Allegheny Intermediate Unit No. 3
B. F. Jones Annex – 311 Ross Street
Pittsburgh, Pennsylvania 15219

Miss Elinor Long, Supervisor
Program for the Visually Handicapped
Department of Special Education
P.O. Box 911
Harrisburg, Pennsylvania 17126

Cooperating Agencies

Developmental Clinic, Children's Hospital of Pittsburgh

Pittsburgh Branch, Pennsylvania Association for the Blind

Department of Special Education & Rehabilitation, University of Pittsburgh

Chapter III

PROCEDURES

Identification and Referral

During the year 1970-71 a primary emphasis of the program, "Plan for Itinerant Educational Consultant Services for Preschool Visually Handicapped Children," conducted by the Allegheny Intermediate Unit Exceptional Children's Program, and funded under Title VI-A, E.S.E.A., was on identification of preschool visually handicapped children, and the establishment of procedures for referral which would facilitate the continuing identification of these children. The Allegheny Intermediate Unit, in cooperation with the Pennsylvania State Department of Education under Title VI-A, E.S.E.A., had conducted during 1969-70, a survey of all preschool handicapped children residing in Allegheny County. The final report of this survey, A Survey to Identify Preschool Handicapped Children Under Eight Years of Age (April, 1970), was used as the first source of identification of visually handicapped children.

In this report sixteen children were listed as being either moderately (partially sighted) or severely (blind) visually handicapped. Of those children listed, eight were found to be suitable for the program. Those who were eliminated could not be considered visually handicapped according to the state standards, were too old to be included, or were already placed in residential programs or institutions.

An essential component of the model program was the establishment of close cooperation between social agencies and educational programs. The Pennsylvania Association for the Blind provided a referral list of children to whom they had been giving social services. This list and the survey report provided the basic population with which the project was initiated. The Pennsylvania Association for the Blind has continued throughout the project to refer children and can be considered the chief source of referral.

In cooperation with the Pennsylvania Association for the Blind and Dr. David Hiles, Pediatric Ophthalmologist, a referral form was designed and distributed to every ophthalmologist

in Allegheny County. This form (See Appendix) enables the itinerant teacher to institute educational intervention even with infants in order to prevent some of the consequences of sensory deprivation.

The Developmental Clinic of Children's Hospital, under the direction of Dr. Grace Gregg, is a diagnostic center of multi-handicapped children. Through referrals from this source the project was able to institute services to several preschool children with very complex physiological problems.

As schools became aware of the availability of preschool services to visually handicapped children, referrals were received from school systems within the Allegheny Intermediate Unit. While most of these referrals involved children who were attending kindergarten, there were instances of nurses or home-school visitors referring younger siblings of children enrolled in the school system. This became more common after the project became better known. In two instances parents who had heard about the program referred their own children.

As the project developed and the itinerant teacher referred children to agency preschools, agencies (such as Easter Seal and United Cerebral Palsy) referred children in their programs who had vision problems.

During the second year of the project four referrals were received from the State Office for the Blind. These children were from families receiving welfare funds and would have been eligible for services earlier had they been identified.

Initial Procedures

Upon referral, the first step was the collection of medical, psychological and social casework data. Available information varied with the source of referral and the degree of disability. Children who had been receiving services from agencies or medical institutions frequently had much data accumulated. Parents were contacted, the program was explained and an appointment to visit the child in the home was arranged if desired by the parents. In three instances, children were initially visited in agency preschools and a public kindergarten.

The procedure for the initial home visit changed and developed as the itinerant teacher gained more experience. The process that finally evolved, and which the teacher found most successful, involved preparing a kit of materials for presentation to the parent. This kit provided an aid to the interview and left the mother with concrete items to which she could refer

after the teacher left. Mothers, even after many visits, could not always understand how the program functioned, what its purpose was, or sometimes the name of the sponsoring agency, the Allegheny Intermediate Unit.

The initial interview included collection of case history data on the child and discussion of materials in the kit. The teacher outlined the school program and, if social services were not already being used, explained to the parent the availability of services through the Pennsylvania Association for the Blind.

Evaluation of the child, during this initial interview, was observational. During the interview with the mother, while the child was held, in a playpen, or was playing with the toys provided by the teacher, the interaction between the mother and child was observed.

Since this was a project designed for visually limited children the child's visual functioning became, of course, a central area of concern. The diagnosed visual acuity of the child was usually known in advance, and those children who had been referred as "partially sighted" became of central importance in determining visual functioning. It was observed how the child explored toys, whether visually or tactually. If the child was verbal, the teacher discussed the toys with the child. If the child used his eyes the teacher tried to determine through structuring the use and choice of play equipment just how the child used his limited vision. If the child appeared to have vision but preferred not to use his eyes, the teacher tried to determine what might motivate the use of the eyes. It was discovered very early in the program that with non-verbal children, light and color were highly motivational in the stimulation of visual functioning. If the child had no apparent useful vision it was determined how the child responded to touch and sound. This was done through the exploration of toys chosen for this purpose.

During the course of the playing, it was noted whether the child's mobility was appropriate for his age and degree of vision, and whether he had developed appropriate body image. The child's understanding and use of language was noted. The teacher usually made all of these observations casually in the course of playing with the child.

The purpose of this observation was not only to assess the child's level of development, but to determine if any of the standardized assessment devices were appropriate in order to plan subsequent sessions. A specific toy that the child could use appropriately with only minimal coaching that would encourage learning was chosen. Hopefully the teacher had anticipated

correctly from the referral information and had such a toy with her. Sometimes such a toy was already in the home and only needed to have the purpose in using the toy explained. The mother was shown how to encourage the child to use the toy properly. With infants the need for physical and auditory stimulation was always stressed.

If the child was totally blind or of very limited vision the teacher-director made arrangements to administer the Maxfield Buchholz Scale of Social Maturity for Blind Preschool Children on a second visit. The information gained from this very directed parent interview with the teacher's observations about the child's level of functioning would become the basis for planning an individual program.

For those older children whose level of functioning was appropriate, the Visual Efficiency Scale edited by Natalie C. Barraga, is useful as a tool to determine levels of visual functioning. It must be noted that this scale was not found useful with children less than five years old or who had other problems such as behavior disorders or lack of receptive language. The scale was most useful with those children who were already in a school experience. The scale was very helpful in explaining to teachers how a child functioned and the kinds of material with which he would probably have difficulty.

Several children observed in the initial home visits were so involved physically and mentally, and the effects of sensory deprivation were so severe that no scales could be used to help determine levels of functioning.

Kit for Initial Interview

In order to help the mothers to understand the program, a kit of materials which could be discussed and later left with the mothers was assembled. A pamphlet was designed by the teacher-director and printed under the direction of the Communications Specialist of the Allegheny Intermediate Unit. This pamphlet was included in the Introductory Kit and becomes a basis for discussion as it detailed the key features of the project and included illustrations. In each kit was a copy of The Visually Impaired Child by Carol Halliday. This booklet on comparative child development helps the discussion of the special needs of visually handicapped children. In the kit is a selection of pamphlets published by the American Foundation for the Blind. Another pamphlet describing all the services of the Allegheny Intermediate Unit is also included as the concept of a

public school system for special education is difficult for parents to understand. Appropriate toys are included for the child.

Instructional Procedures

The instructional procedures were conducted for the two years by the project teacher-director, who served as an itinerant teacher in the homes of the children, in addition to being the project director and consultant to other preschools and institutions. During the year 1970-71, one aide was utilized, which proved so successful that three aides were provided for the year 1971-72.

From the results of the evaluation, a plan was developed for the educational instruction of each child. While all areas of development were considered, usually intensive instruction in one or two areas was planned. The primary areas were mobility, language development, efficient use of residual vision, self-care skills, cognitive skills or adaptive behavior and socialization.

Development of mobility included gross motor and fine motor skills as well as development of body image. Some of the children were crib-bound, not able to sit up or walk. For these children mobility training meant the development of strength in arms and legs and the use of educational techniques, mainly behavior modification, to encourage them to sit up and later to stand and to walk.

The development of body image included identification of body parts. This phase, of course, involved language development and the development of meaningful interpersonal relationships with the children in addition to the mobility.

Language development was an integral part of all the other instructional areas. There were, however, children who had developed no language and no speech. These children were taught to parrot sounds and to develop receptive language through the use of records, games, etc. The teacher and aides constantly labeled, categorized objects as they worked to enlarge the children's experiences. This not only enlarged vocabulary, but enhanced the concept development of the children.

Many of the children required instruction in basic self-help skills. Children who did not eat solid food, or drink from a cup, were taught to do so, and their mothers were instructed in the methods of developing these skills. Mothers were given instruction in toilet training, and in the techniques of teaching blind children to dress and wash themselves.

Adaptive behavior, meaning cognitive skills such as problem solving and task-oriented behavior, was stressed in order to prepare these children for future educational procedures. Manipulation toys and developmental toys, such as stacking boxes, were recommended and their use demonstrated to the mothers.

At all times the efficient use of residual vision was stressed. Parents were taught to encourage their children to function visually whenever possible, to find things and to help with their own care—teachers in preschools were instructed in specific techniques. Tensor lights and easels were provided for their classrooms, and materials were outlined, enlarged and otherwise adapted for the use of the children.

Because of the severe sensory and social deprivation of the children, socialization was an important objective. With some children this involved only the establishment of relationships with other human beings. With some it involved a restructuring of the family complex to allow the child to become a contributing member. With others, socialization involved nursery school experiences with normal children.

Paraprofessionals

An important objective of this project was the use of paraprofessionals to increase the contact time with children. It was proposed that with in-service training aides could help carry out individual programs of instruction. Because of the success of the one aide used in the 1970-71 project, money was budgeted to hire three part-time aides during the 1971-72 project.

Finding appropriate aides was a major problem. The itinerant nature of the job and the low salary scale for part-time positions caused this to be a distressingly unrenumerative job which eliminated most applicants. The need for a car and a willingness to travel eliminated another large percentage of the applicants. Only one aide was selected through the application files of the Allegheny Intermediate Unit. A second aide was discovered through word of mouth, and the third aide, who was not hired until December, was found through the second aide. Suggestions for future hiring would be to increase the pay scale if possible, or, more importantly, to provide mileage expenses.

The training of the aides was on an in-service basis and individual. As soon as an aide was hired the itinerant teacher spent time discussing the program and going over selected reading materials. All of the aides read or had available to them as main sources:

The Visually Impaired Child: Growth, Learning, Development Infancy to School Age, by Carol Halliday.

Techniques for Observing Normal Child Behavior, by Nancy Carbonara.

Understanding Your Blind Child, by the New York Association for the Blind.

No Time to Lose and No Place to Go, by Pauline Moor.

Professional Preparation of Teachers of Multiply Handicapped with Special Concern Directed Toward the Child with Both Auditory and Visual Impairments, from the Department of Special Education and Rehabilitation, the University of Pittsburgh.

Other resources were offered to individual aides as they were assigned to specific children. When it was decided which child an aide would be working with, the itinerant teacher took the aide with her to observe the itinerant teacher working with the child. They would discuss objectives, materials and methods. If the child were especially difficult several observations were arranged. The teacher also observed the aide with the child and gave suggestions. Once the aide began working alone with a child the teacher usually began to see the child on a regular basis less often, stopping to observe and make suggestions about once a month. The teacher and the aide talked by phone, usually once a week or more often if necessary.

The decision about which children should receive the services of the aide was made by the itinerant teacher. Those children who could not seem to make what would be considered acceptable progress for their condition without much help and specific techniques were given priority. Also, they were children whose parents could not do for them those things that needed to be done. For instance, all of the rubella children except one were sufficiently involved to present real problems in management both at home and in school situations. They needed constant one-to-one attention for any learning to occur. They received priority on the use of aides. One little boy seemed capable of learning new behaviors only if taught very specifically. His mother was not able to think of him as a child who could become more independent and encouraged his helplessness. An aide worked with that child and made unexpected progress. Another child who lived in an isolated community desperately needed a nursery school experience to encourage him to use his apparent but undeveloped abilities. Since no school experience could be arranged, an aide went to work with him each week, providing many toys, materials and experiences. This child made magnificent progress in his use of his residual vision, language development, ability to play appropriately and in concentration.

Aides were also provided for blind children starting new nursery school experiences. Once the regular teachers became acclimated to the situation the aide was removed from the one child who was otherwise normal. A multiply involved blind child who was accepted into a nursery school kept her aide.

	1970-71			1971-72	
	Visits by Aide	Visits by Teacher	Difference in Contact Time	Visits by Aide	Visits by Teacher
Child 1	78	20	82	24	20
Child 2	0	32	3	48	13
Child 3	0	0	35	48	13
Child 4	0	32	89	90,63	32
Child 5	0	8	0	16	8
Child 6	0	16	18	42	8
Child 7	5	20	0	0	15

The above chart illustrates the contact times spent with children (not the length of time) by the aides and teachers. In those instances where the difference is negligible it should be pointed out that while an aide took over time with a child, the teacher could be seeing another child. Also while the teacher usually spent no longer than 1½ hour with a child (except occasionally), the aides usually spent 3½ hours with a child, thus giving more service per contact as well as more contacts.

The first aide hired in 1971-72 was a woman with a nearly grown family. She had a high school education and experience as a Brownie leader and Cub Scout den mother. She had no previous experience with handicapped children. After training this aide was used in school settings working full mornings three days a week. The children she worked with were probably the most severely involved in the program. This aide was able to follow directions and carry through an established program beautifully. She seemed to have an instinct for what was appropriate handling of difficult situations and was truly invested in developing independent behavior in the children she worked with.

The second aide hired was a young woman with two years of college as an art major. She was bilingual and had experience working with emotionally disturbed teen-agers. She had

not had experiences with very young or handicapped children. After training, this aide worked with three different children in the home, and one of them in a nursery school. This aide was able to use equipment and materials in creative ways to bring about specified behavior. This aide was also able to develop good rapport with parents and was able to judge situations where additional help (social worker) was needed. She also had an investment in seeing that the children she worked with reached their highest level of ability.

The third aide was a young woman with a Master's Degree in Human Development. Her work experiences had been in intercultural, Spanish language situations in Southern California and Mexico. She had many experiences with children and limited experiences with emotionally disturbed children. She was taking a course in Emotional Disturbance at Duquesne University. Because of her exceptional personality and sensitivity the itinerant teacher decided to have her work exclusively with one specific child whose development has been disrupted by what appeared to be emotional difficulties associated with her blindness. This aide's schedule was unusual in that she visited this child nearly everyday—at first for only a few minutes and then as the child was able, for longer periods of time. This was the kind of attention the child needed but could not have had without the availability of this exceptionally qualified aide.

Mobility Specialists and Student Teachers

Throughout the two-year course of the project, several mobility students and student teachers of the visually handicapped spent practicum time with the itinerant teacher.

Three education students spent two weeks traveling with the itinerant teacher, thus getting an overview of the kinds of services offered and the types of children involved. Two weeks was enough time to cover nearly all of the cases involved in the project. The time between children was spent in discussion of individual cases.

Two mobility specialists did independent studies using three of the children in the project. Two of the reports are included in the case logs. The children were chosen by the itinerant teacher as having special mobility problems that needed the expertise of a mobility specialist. Since the itinerant teacher is not trained in mobility this was an appreciated addition to the project.

Nursery Schools and Institutions

A primary goal of the project was to place visually handicapped youngsters in appropriate preschool programs. In order to do this it was necessary to become familiar with all of the options for preschool education in the county. The Pittsburgh Area Preschool Association, a professional organization for those interested in young children, has a membership list with addresses which proved useful in finding teachers in different areas but schools were not registered. Through Information Volunteer Services, a public service information center, it was discovered that one could call and ask for a nursery school in a specific area. This is how the itinerant teacher found out about nursery schools. It remained to visit each one and evaluate its program to discover if it would be suitable for a handicapped child. In order to facilitate the evaluation process, a form was used (See Appendix) and eventually a file containing 25 different nursery schools was established.

The same process was used in determining the availability of residential schools and institutions, as it was recognized that this may become necessary for some of the more severely involved children in the project. A point was made of visiting each residential facility and offering consultant services to any preschool child with visual problems. Those facilities visited included:

1. Western State School and Hospital
   333 Curry Hill Road
   Canonsburg, Pennsylvania 15317

2. McGuire Memorial
   2119 Mercer Road
   New Brighton, Pennsylvania 15066

3. D.T. Watson Home for Crippled Children
   Campmeeting Road
   Leetsdale, Pennsylvania 15056

4. Allegheny Valley School for Exceptional Children
   315 West Prospect Avenue
   Pittsburgh, Pennsylvania 15205

5. Home for Crippled Children
   1426 Denniston Avenue
   Pittsburgh, Pennsylvania 15217

The Toy Library

Play has long been recognized as the natural occupation of children and that toys are the child's tools. It is assumed that if parents provide the correct toys in the proper developmental

sequence along with the opportunity and space to use them, learning and development will occur naturally.

Parents of handicapped children need help, however. Not only are developmental lists and age appropriate labels prepared for normal children, but a child with a sense modality missing or an immobile child will use a toy in a different way or perhaps find a classic toy such as a small car meaningless. Many handicapped children need to be taught how to play.

To encourage parents to stimulate their child's development through play, the Title VI preschool project has established a toy library which has become a key feature of the program. Toys and equipment with specific developmental goals in mind are made available to the children enrolled in the project through a check-out system.

A cataloging system was developed based on the system used by the Regional Instructional Materials Center. However, since the project included infants, the toy library contained many articles not available through the materials centers and, therefore, contained new categories.

Each toy is recorded on two 4 x 6 file cards. The first card is an alphabetical card which contains the name of the item and the catalog number assigned to it. This is the check-out card on which is recorded the date loaned, the child's name, and the date returned. This card is kept in an alphabetically arranged file.

The second card is the catalog number card which contains complete descriptive information about the item. Many items are cross-referenced. Following are sample cards:

34-001 / 22-007
MEMORY BEND

Date Out	Name	Date In
3-26-72	Jason Strom	

34-001

Memory Bend

Encourages motor planning and helps develop the concept of directionality. Sturdy base holds three feet of plastic wire that bends into various three dimensional shapes. The child's hand moves the block from left to right, up and down, over and around, toward and away as the eye tracks the block across the midline to the end of the wire. Complete with Instructor's Guide.

Educational Playsystems, Inc.
Catalog No. 495

1 set $4.00 PSV-16
January 13, 1971

Catalog System and Sample Items

20-000 Infant Materials

- 20-002 Roly Poly Chime Bear
- 20-004 Rainbow Twirler/Turning Balls
- 20-007 Five Finger Exercisor
- 20-013 Infant Chimes Mobile

21-000 Printed Material

- 21-005 First Picture Book
- 21-006 How to Play With Your Baby - Ashton
- 21-007 Your Child from Two to Five Years - Roufberg

22-000 Concept Formation

- 22-001 Concept Builders—Animals
- 22-003 Everyday Object Counters

Here the number progression was interrupted to enable adding more categories as the library grew:

34-000 Sensory Motor

- 34-002 Basic Weight Tablets

35-G.000 Gross Motor

- 35-G-001 Wheelbarrow Jr. Size
- 35-G-007 Activator (Cross referenced under Infant Materials, 20-000)

35-S.000 Small Motor

- 35-S-001 Jiffy Dump Truck
- 35-S-009 Fit A Space
- 35-S-014 Turning

36-V.000 Perceptual Development—Visual

- 36-V-001 Lite-Brite
- 36-V-004 Colored Inch Cube Designs
- 36-V-014 See Me Mirror
- 36-V-019 Tri-Color Viewer

Since a key purpose of this project is to develop the efficient use of residual vision, this 36-V category is probably the largest category in the library.

36-A.000 Perceptual Development—Auditory

- 36-A-001 Melody Push Chime
- 36-A-009 Songs to Grow On—Record
- 36-A-013 Tambourine

36-T.000 Perceptual Development—Tactile

- 36-T-001 Texture Ball

36-O.000 Perceptual Development—Olfactory

37-001 Eye-Hand Coordination

- 37-001 Hammer Ball Set
- 37-016 Peg Bus
- 37-023 Learning Tower

Toys were selected for specific children with very implicit goals in mind. The following examples illustrate this very precise use of play materials.

P., an anophthalmic infant of fourteen months, was not using his legs as he should. The Playtentials, Series Two, kicking board was placed in his crib and P. placed so that if he straightened his legs he would naturally kick it and the bell attached would ring. Soon P. was kicking it by choice in order to hear the bell, thus strengthening his leg muscles and developing an awareness of his feet as part of his body—over which he could have control.

J., a 2½-year-old cerebral palsied child, had not seemed to develop the concept of cause and effect. A toy was selected that contained a series of doors behind which animals were hid. Each door was activated by a simple mechanism—a push button, a switch, etc. J. was taught to work the mechanisms and delighted in seeing the animals pop out. He had to use his hands, concentrate his vision and attention on a specific object and eventually learned that he could have an affect on objects around him.

S., a 3-year old, would not use her limited vision and had not learned to play with any toys. The teacher found small colored plastic discs through which the light shined. By putting them up to her eye S. could see the different colors. By looking through the discs she learned the names of the colors and eventually was able to sort them into matching plastic cups, thus learning several new skills.

T. was a hyperactive 3-year old with very limited vision. It was difficult to get him to sit still for even a minute to attend to looking at something. Colorful flannel board stories were selected and he not only sat and listened, but wanted to learn how to manipulate the characters himself. He learned to tell "The Three Little Pigs," "Humpty Dumpty," "Little Red Riding Hood," and "Hey Diddle Diddle," using his vision and hands at the same time to work the illustrations.

C., a six-month-old blind infant, learned to entertain himself in his crib by working an activator—an apparatus which rings a bell or sounds a wood block when the proper string is pulled. He would pull the proper string on command when his mother would say, "Ring the bell."

J., an apraxic child with severe motor retardation, was stimulated to move his eyes toward sound and use his arms by playing with a chime push toy.

When introducing a toy to the child the teacher would play with the child until he understood how the toy was to be used. The mother was always present and the teacher explained the purpose for using the particular toy to the mother. It was discovered that most mothers think that playing is just a means of passing time. They need to be taught the importance of play in the development of their child. They also need to be taught a proper respect for playthings. Most parents don't know what standards to follow in selecting toys nor how to care for them properly. The itinerant teacher found mothers very appreciative of help in this area because young families spent a great deal of money on toys and had learned through bitter experience that toy advertising, especially on television, is very misleading.

The itinerant teacher found two books very helpful to use with parents in helping them make decisions about toys. How to Play With Your Baby by Athina Ashton describes the development of infants through the first two years. It suggests many ways of playing with a baby that will enrich his life and increase his potential. Your Child from Two to Five Years by Ruth Roufberg is a comprehensive guide to toys, their selection and proper use. It includes equipment for

physical development, books for language development, play materials fostering self-identity, blocks, dramatic and imitative play, manipulative play, free and creative play, art materials, nature and science. Both books are inexpensive, attractive and written in a manner that is easy and pleasant to read. The indexes include helpful charts and lists. Although the books are written for normal children, the levels of development are so clearly presented that most mothers can find just where their child is functioning.

In selecting the toys and equipment for the toy library, the main source was the catalogs put out by the major supply companies. Since these catalogs tended to handle mainly "educational" toys and those items most likely to be in schools, the itinerant teacher found it very helpful to visit toy departments in large stores to select toys which would be more suitable for home use and which would more nearly duplicate what parents could provide. The catalog, Commercially Available Instructional Materials for Use in the Development of Elementary Readiness Skills in Young Visually Handicapped Students, published by the American Printing House for the Blind, and available through the Instructional Materials Reference Center for Visually Handicapped Children, is the most comprehensive listing of materials and sources available. Anyone planning a materials library should use this as the chief reference.

Chapter IV

THE CHILDREN

Criteria

In 1970-71 the criteria for accepting children in the program were:

1. Residence of child is Allegheny County.
2. The child is under eight years of age.
3. The child meets the definition of "visual handicapped" as accepted by the State Bureau of Education.
4. The child is not currently enrolled in a public special education program.
5. Parents agree to participate in the program.

In 1971-72 the following criteria were followed. The subjects included:

1. Visually handicapped children who have been identified during the 1970-71 school year.
2. Visually handicapped children who are referred through the previously established referral procedures.
3. Visually handicapped children who reside in adjacent institutions.

Description

The incidence of ophthalmological diseases and additional disorders reported for the children who were served in this program are shown in Table 1.

The number of times each child was contacted and the placement or disposition of the child at the end of the 1971-72 school year are indicated in Table 2.

Sample Case Logs

The case logs which follow the tables have been included in this report in order to give a complete picture of the kind of services rendered by the project and the types of children served. While the logs are accurate as presented, they should not be considered complete case studies of specific children as they include only educational data.

Table 1

DIAGNOSES CHART

VISUAL	INCIDENCE	OTHER	INCIDENCE
No Optic Nerve (Parent's Description)	1	Hyaline Membrane Disease	1
Retrolental Fibroplasia	3	Albinism	2
Retinal Detachment	3	Brain Tumor	1
Anophthalmia	1	Growth Defect	1
Microphthalmos	3	Rubella Syndrome	4
Mystagmus	8	Hearing Disability	1
Myopia	4	Heart Involvement	6
Amblyopia	1	Mental Retardation	3
Strabismus	3	Microephaly	2
Hypoplastic Discs	1	Cerebral Palsy	2
Iris Atrophy	2	Downs Syndrome	1
Myopic Choriotitis	1	Hydrocephaly	1
Cataracts	8	Psychomotor Retardation	1
Coats Disease	1	Petit Mal Epilepsy	1
Congenital Glaucoma	2		
Hyperopia	1		
Photophobia	2		
Vitrious Hemorrhage	1		
Micro Corneal Coloboma	1		
Optic Atrophy	1		
Ocular Motor Apraxia	1		

Table 2

EVALUATION SUMMARY OF PRESCHOOL CHILDREN

Child No.	Age at Time of Report	Number of Visits 1970-71	1971-72	Disposition	Cooperating Agency
1.	5-5	1	0	Western Pa. School for Blind Children	Pa. Association for the Blind
2.	4-9	2	15	Referred to Kindergarten	Pa. Association for the Blind
3.	1-10	8	12	At Home	Pa. Association for the Blind Department of Public Welfare
4.	1-4	3	8	At Home (Foster)	Pa. Association for the Blind Developmental Clinic Catholic Charities
5.	5-2	32	32	McKeesport School for Retarded Children	Pa. Association for the Blind Developmental Clinic Mental Health and Mental Retardation
6.	4-2	5	1	Pa. Association for Retarded Children Preschool	Pa. Association for the Blind Developmental Clinic Pa. Association for Retarded Children
7.	7-5	2	0	In School	
8.	5-0	10	3	In School	
9.	5-5	3	0	In School	
10.	5-4	3	0	In School	
11.	6-5	5	0	In Vision Class	
12.	6-6	10	0	In Vision Class	Pa. Association for the Blind
13.	7-8	10	0	In Parochial School	
14.	7-6	3	0	In Vision Class	
15.	5-5	8	0	Rehabilitation Center	Pa. Association for the Blind Department of Public Welfare

Child No.	Age at Time of Report	Number of Visits 1970-71	Number of Visits 1971-72	Disposition	Cooperating Agency
16.	6-5	1	0	In School	
17.	6-7	2	0	In Vision Class	Pa. Association for the Blind Department of Public Welfare Developmental Clinic Office of Blind
18.	5-7	32	1	Nursery School	Pa. Association for the Blind
19.	3-11	8	8	At Home	Pa. Association for the Blind
20.	3-6	7	8	At Home	Pa. Association for the Blind Developmental Clinic
21.	8-6	32	13	Western Pa. School for Blind Children	Pa. Association for the Blind Developmental Clinic
22.	6-7	20	20	Moved to Florida	Pa. Association for the Blind Developmental Clinic
23.	4-2	3	0	In Parochial School	Pa. Association for the Blind Developmental Clinic
24.	9-5	1	0	In Parochial School	Developmental Clinic
25.	5-5	6	20	Preschool	Developmental Clinic Mental Health and Mental Retardation
26.	3-0	9	2	Institutionalized	Pa. Association for the Blind Developmental Clinic
27.	4-0	16	8	Cerebral Palsy Preschool	Pa. Association for the Blind Developmental Clinic United Cerebral Palsy
28.	4-5	16	0	Western Pa. School for Blind Children (Preschool evaluation)	Pa. Association for the Blind Developmental Clinic
29.	3-9	0	3	Enrolled in Nursery School	Department of Public Welfare Office of Blind

Child No.	Age at Time of Report	Number of Visits 1970-71	1971-72	Disposition	Cooperating Agency
30.	3-5	0	1	Preschool	Department of Public Welfare Office of Blind
31.	3-6	0	8	At Home	Department of Public Welfare Office of Blind
32.	14-2	0	1	At Home	Mental Health and Mental Retardation
33.	5-7	0	20	In School—Referred to Listen Disabilities Class	
34.	4-8	0	1	At Home—Kindergarten Next Year	Pa. Association for the Blind
35.	2-8	0	3	At Home	Developmental Clinic
36.		0	16	Western Pa. School for Blind Children	Pa. Association for the Blind Developmental Clinic
37.	6-5	0	30	Referred to Vision Class	Pa. Association for the Blind Easter Seal Society
38.	1-9	0	1	At Home	Pa. Association for the Blind
39.	1-4	0	8	At Home	Pa. Association for the Blind
40.	1-2	0	5	At Home	Pa. Association for the Blind Developmental Clinic
41.	0-3	0	1	At Home	Pa. Association for the Blind
42.		0	1	At Home	Pa. Association for the Blind Developmental Clinic

Case One

Child: T., Male
Birthdate: 4-10-68
Diagnosis: Myopia, Mystagmus
Vision: 20/200 20/200
Referral: County Survey

Services 1970-71:

T. was a bright, pleasant four-year old already enrolled in a neighborhood nursery school. After discussing his visual situation with T.'s mother, the itinerant teacher spent two sessions observing him at nursery school. It was noted that T. avoided those activities which required eye-hand coordination, often did not finish tasks, was restless during group activities and unusually cautious in gross motor activities such as riding tricycles. He was very verbal, however, and knew all the letters and numbers. T. scored very erratically on the Barraga Visual Efficiency Scale and verbalized deep distress throughout. The itinerant teacher felt that this was a child who needed low vision stimulation and work on fine motor skills, so arranged to visit the home weekly. Since T. would be entering a public school kindergarten in September, the itinerant teacher informed the kindergarten teacher of his needs and offered to visit the classroom in a consultative capacity when T. entered kindergarten.

Services 1971-72:

The itinerant teacher visited T.'s school early in the year. She observed T. for one full morning and had a conference with his kindergarten teacher. Both teachers agreed that T. appeared to be functioning well in the group. His small motor skills were noticeably below what appeared to be the norm for the class, but there were several children who were less skillful than he. The kindergarten teacher felt that this was to be expected in any class. She was accustomed to working with children on several ability levels.

In anticipation of a learning problem which in fact never occurred, T.'s parents had had him examined by a clinical psychologist before entering school. When the results of the interview became available, another conference was held between the kindergarten teacher and the itinerant teacher of the project. The test results showed T. to be of high average intelligence but the examiner indicated he thought T. might have a gross motor disability. The psychologist recommended that T. be placed in a class for learning disabled children which met on Saturdays in a community near T.

Both the kindergarten teacher and the itinerant teacher felt that this was not a good recommendation, and upon consultation with the teacher of the special class it was learned that the program would not benefit T. Both felt that his visual handicap, together with his lack of practice due to overprotection, was the cause of his motor problem. The teachers agreed that the parents were overly anxious and that the child was not as handicapped as the parents had come to believe. Conferences with the parents were held at school where it was stressed that T. was really quite a normal little boy and that he should be encouraged to take part in as many activities with normal children as possible. Since the kindergarten teacher was conscious of T.'s limitations, but even more important, very aware of his abilities and felt comfortable in dealing

with him in the classroom, it was decided that the role of the itinerant teacher might be to interpret his needs to his parents.

T. made fine progress throughout the year and performed within the top third of the class in all but motor skills. He made definite progress in this area also and while he remained in the bottom third, he in no way could be considered abnormal in his performance. At the end of the year the itinerant teacher observed for another full morning and, except that he was the only child in the room with glasses, would not have been able to pick him out as a handicapped child. The children were doing very sophisticated readiness tasks on ditto sheets that were confusingly designed. T. finished all sheets quickly and accurately. He had no problems in completing the Metropolitan Readiness Test administered by the school counselor. His only errors on the test were reversals of "d" and "b," "g" and "q." The itinerant teacher, the teacher, the parents and the counselor all agreed that he was quite ready to go into the first grade and be expected to do well. The itinerant teacher turned his records over to the vision itinerant program of the Intermediate Unit with the recommendation that he be checked on occasionally, but that no special materials were needed unless his later performance indicated it.

Case Two

Child: D., Male
Birthdate: 12-17-65
Diagnosis: Bilateral optic atrophy secondary to hydrocephalus
Vision: O.D. light perception
O.S. counting fingers
Referral: Easter Seal Society

Services 1971-72:

D. had been placed in the Easter Seal preschool due to his hydrocephalus. However, because of his optic atrophy caused by a blocked shunt in 1969, the preschool was having difficulty with most of the tasks in the highly structured kindergarten. The Easter Seal social worker called the itinerant teacher to see if D. was eligible for services. D. was observed in the class and found to be a very slow reacting child with poor motor coordination, although he appeared to be able to see, he seldom chose to use his eyes. He felt objects and bumped into furniture and toys. When doing puzzles and art projects, he seldom looked at the work. He turned his head all around as if gazing about the room. He was very alert auditorally, however, and was quick to make verbal responses to all questions. He verbalized excessively, especially when under pressure to accomplish a task which required vision to the point where he was a disturbance most of the time.

On that first visit the itinerant teacher suggested several ways in which materials could be modified, such as blacking in the background shapes of the puzzles, outlining heavily all the flat visual items he was required to work with, keeping his many pieces of equipment on a tray so he wouldn't lose them, having a specified area within which to search when he did lose them. He needed very specific verbal directions to help him examine objects and pictures. He could make good use of an easel for much of the work he was required to do. Because of the variant lighting conditions and the many shadows, teachers were shown how to use a tensor light to improve the visual conditions. As he began to use his eyes more he became quite dependent on this extra light.

One of the major problems was that often D. was unsuccessful because he could not physically do the manipulations required to complete a task. For instance, he made many errors in counting games, not because he couldn't count or didn't understand number concepts, but because the items he was asked to count were too small and close together for him to tell where one thing left off and the other began. Items that were overlapped were missed entirely. On another task he was to match puzzle pieces of words with a corresponding picture piece. He knew all the words and pictures but was never able to finish because he physically couldn't work the puzzles. Since all of the children in the class had some kind of physical handicap, it was immediately realized that this was true of several of the children. The itinerant teacher and the Easter Seal teachers spent some time on task analysis and evaluated different learning materials together.

The teachers encouraged D. to examine all items tactually to the exclusion of visual examination. The only thing that he consistently used his eyes for was to see letters. He apparently had an emotional investment that was strongly reinforced both at home and in school for learning letters. He knew the complete alphabet by sight and could recognize quite small letters with ease. It was almost impossible to get him to look at pictures and objects.

The itinerant teacher assessed D.'s visual effectiveness, using the Visual Efficiency Scale. This took several visits to complete because he tired after two or three items and had to be almost forced to move across a line. His tendency was to look at the first choice and choose it without looking at the others, until he came to the items with letters or words. These he examined carefully and made intelligent choices.

As a result of observing his ability to see letters very well but his refusal to use his eyes generally, it was decided to work D. through a program of training in the efficient use of low vision. The teachers were taught how to encourage D. to use his eyes rather than his hands in examining objects. The Montgomery Public School Lessons were used as a basis for weekly sessions in the development of efficient use of his residual vision.

In March a staffing was conducted at the Easter Seal Center. Those professionals taking part were: the Easter Seal teachers, physical therapist, social worker, a psychologist from his home school district, a psychologist from the Intermediate Unit, and the itinerant teacher. D. was recommended for the vision classroom in the special center that served his school district. It was felt that although he did have residual vision that he could use, there were times when the pressure was such that all his reactions slowed down and during those times he functioned as a totally blind child.

Toward the end of the year D.'s interest in letters and words increased. However, the practice in eye-hand coordination, form, color and picture recognition began to show results in his more willing participation and greater success in the school activities. It was the opinion of the itinerant teacher that D. would indeed be ready for first grade work in the vision classroom.

Case Three

Child: J., Male
Birthdate: 12-5-68
Diagnosis: Albinism, Nystagmus, Myopia, Strabismus
Severe bilateral talipes (deformities of the feet)
Poor coordination, developmental retardation
Vision: Not Available
Referral: Pennsylvania Association for the Blind

Services 1970-71:

J. was visited bi-weekly by the itinerant teacher. He was found to be a pleasant but quite retarded child. He was not able to sit, crawl, or walk. He could not talk. He liked to play with toys, however, especially those which made noises. He could not use toys properly, just move them about. It was decided to work on two areas—sitting and the meaningful use of toys. A chime mobile was used to encourage him to sit. He could reach it to make it ring only when sitting. By the end of the program he could sit unsupported for nearly one-half hour. To teach him meaningful play he was taught to nest metal dishes of different sizes. He enjoyed this and became quite compulsive about stacking them. It was decided to try him on a toy with parts to be worked. One with little doors to be opened by working a simple fastening was selected (button to push), (switch to pull), (door to slide), (dial), etc. When the fastening was worked properly, a little animal popped out. J. took great delight in the toy. He learned to close all the doors after the animals popped out and to take an adult's hand and place it on the fastening. He knew what needed to be done but was never able to use enough force to make it work. The mother was to continue with this over the summer and with other tasks to develop strength in his leg and arm muscles.

Services 1971-72:

At the beginning of the second year of the program it was decided that J. was a child who could benefit from the frequent sessions with an aide that became available with the additional funding. It was arranged that the aide would visit once a week and follow a specific program. The goals were to encourage J. to use his right arm, to support himself on hands and knees, to begin parrotting speech sounds, and to perform increasingly complicated adaptive tasks. Specific toys were chosen to encourage the using of his hands. The aide played with him on the floor motivating him through her interest in his successes. To encourage verbal behavior, music and songs were used, many encouraging the use of or recognition of different parts of his body. He was encouraged to imitate the aide. The aide's report follows.

Early in the school year the Developmental Clinic of Children's Hospital conducted a staffing on J. The itinerant teacher was invited to sit in on the discussion and give an educational assessment. It was the concensus of those present that J.'s greatest handicap was his "severe" retardation. It was felt that his physical disabilities, while very real, were not the cause of his developmental lag. It was noted that while his vision was not normal he appeared to use it. It was felt that the child's future should be planned and that eventual placement in an institution may be a realistic choice. The social workers agreed to begin discussing that eventuality with the parents and that the itinerant teacher should encourage the mother to apply to as many agency preschools as possible.

The aide continued to see J. weekly and sometimes twice weekly. The itinerant teacher observed and made additional suggestions every three weeks. It very quickly became apparent that J. had a great deal more receptive language than had been realized, so verbal directions became a central part of his program. The aide felt that he made such quick progress in getting up onto his knees and enjoyed being up so much that a walker might encourage him to move about independently. The itinerant teacher consulted the Easter Seal Society and their therapist examined J. She discovered that he was not yet ready for a walker as he had not developed either his protective reflex or his alternating reflex. She suggested several things short of therapy that his mother and the aide could do to encourage these reflexes. J.'s orthopedic physician would not prescribe therapy, but did approve of our consulting about the walker. He said that he would appreciate it if J. learned to walk before his next operation during the summer.

J. was accepted at the Cerebral Palsy preschool in March. It was anticipated that there might be quite a severe separation crisis, as this was a child who was very overprotected and had never even been left with baby-sitters other than close relatives, and then only for emergencies. The itinerant teacher could not be present the first day due to other appointments but stayed the second day. J. came in very happy, was placed in a corner sitter on the floor and played happily with the toys provided. He took part in every activity with great joy and eagerness. He remembered procedures from the day before and when his name was called for the roll, raised his hand and called out "Here!" He did not express any anxiety. It should be noted that when the itinerant teacher greeted him, he did not appear to recognize her as somebody he had known any longer than anybody else. It had been observed by the itinerant teacher before that he seldom chose to make eye contact with persons about him and his mother had said that he never looked at any of the family members. This behavior was carried over into the preschool. The mother also stated that he never appeared especially pleased to see her or other members of the family when they had been away from him. These behaviors are puzzling in contrast to his obvious interest in the activities around him and his pleasure at succeeding in tasks that have been set for him.

Feeding at school became a problem in that he was so distracted by all the other children and adults that he merely played with his food. This problem was solved through rewarding him with his favorite food, applesauce, when he ate properly. A more difficult and serious problem became evident when it became apparent that J. did not know how to chew. This had been known at home but not recognized as a serious problem because he ate an adequate diet and handled a spoon well. He was cooperative in that he would try to imitate chewing, but couldn't seem to catch on. The teachers at the school feel that this is important for speech development and have set learning to chew as a chief goal.

Arrangements were made for the aide to come to school to work on the program that had been planned previously. She also helped with the feeding.

J.'s progress in socialization, mobility and receptive speech had been so much faster than anyone had anticipated, that the director of the preschool in conversations with the itinerant teacher indicated that she felt his abilities were greatly underestimated. The aide had been saying this since she started working with him.

It is hoped that J. can take part in the Cerebral Palsy day camp during the summer. The mother is objecting because she fears for his safety. This overprotection has always been a problem. The mother will not allow her children to try situations where they might be vulnerable. She also over-mothers in little ways such as ironing clothes fussily and not sending soup in a thermos because it might culture. This is a situation which the itinerant teacher and the social worker

are still trying to resolve with the mother, as both feel J. might progress more if more experiences are made available to him.

Report of Instructional Aide

I began visiting J. in his home on November 11, 1971, on a once-a-week basis, however, as of December 3, I visited him twice a week for 2½ to 3 hours each session. He was a very pleasant child, but would not talk and mostly ignored those around him. With the use of both educational and non-educational toys, we began to work together.

J. got discouraged very easily when he did not succeed at a task on the first try. Because of his awareness of his failures, J. would not attempt certain tasks. Those which he did attempt without immediate success he quickly gave up. When J. was shown how to do a task he would not follow with his eyes. For this reason I used loud sounds and quick motions to attract him to the object and encourage him to follow the task with his vision. Then, by talking to him, giving him confidence and offering my help at all times, or when he requested it, I gained his confidence and he began to attempt various tasks. Upon his failures I kept reassuring him that all was well and that I would help him this next time. As his self-confidence has grown, J. has come to where he will now try almost all tasks and will only ask for assistance after three or four attempts. However, at times he will not attempt a task in the presence of others, but will practice this task when alone and once mastered will show it to you. This is what J. did in both learning to sit himself up and to get up on his knees. In both instances I showed him the motions twice and dropped the task feeling it might not be the time to do so, but within one week, which was two visits, he showed me his accomplishments.

When we began to work together, J. had just learned to keep himself sitting up when put into a "legs-out" position. He would not bend either knee nor would he use his right arm or hand except for the support of his body. He moved around by dragging himself on the floor. By the end of December, he was sitting himself up and by the end of January he was getting up on his knees alone. At this point we visited the physical therapist at the Easter Seal School with the hopes of getting a walker for J.; however, the physical therapist felt that he was not ready for a walker. She showed us some exercises and we made an appointment to see her within three weeks. After the second visit, J.'s mother felt he was not being given enough time between sessions to benefit from them, that it might be wiser if we saw the physical therapist once every five weeks, rather than every three weeks. I agreed and we made those arrangements. J. learned how to sit in three different positions, sideways, legs straight out, and cross legged. He has also learned, on his own, to pull himself up on his knees.

With the use of certain toys, J. began to use his right hand more and more. By holding his left hand and handing J. a peg he would take it with his right hand and put it in the hole. We have done similar exercises throughout the seven months and on several occasions J. has not only reached for objects with his right hand, but taken two objects, one in each hand, and placed them in position at about the same time. He has also learned to help his left hand with his right hand. He has learned to hold his plate with his right hand while feeding himself with his left. We have done finger exercises and when J. saw and heard me snap my fingers he tried to imitate. He found that he could not make a noise with his fingers, and substituted it with a similar sound with his tongue. J. has learned some of the different parts of his body (feet, legs, knees, hands, fingers, hair, nose, ears, eyes and mouth).

We also worked with sounds that could be made by using the different parts of the body. J. learned to clap his hands and tap his feet. We made different sounds with the mouth and I taught him to say "car" (which he calls "ar"), "yes," "meow," "moo" (these were learned by means of songs). J. surprised us one day with the word "elbow," he repeated it only having heard it once in a conversation between his mother and myself. I then taught him to say "away," "boy," and "shoe." With his family he learned to bow for grace before meals and say the word, "amen." His receptive language I found to be excellent. J. can comprehend just about all of what is said to him. While working with J. I have found that he knows by name the objects in his home with which he has had at least visual contact. He is also aware of the names of certain animals that he has either seen pictures of, heard songs about, or seen alive. To some of these animals he has been able to associate the sounds that they make (pig, duck, lion) and in some cases imitate them (meow, moo, hee haw, cock-a-doodle-doo). However, he has not yet been able to recognize the names of the different colors.

In March J. entered a Cerebral Palsy preschool where he has adapted nicely. At first the school was not aware of certain ways in which J. had learned to eat and it was confusing for him and the teachers. At home when they said grace they put their hands together, but at school the teacher would instruct the children to fold their hands; he does so, but with the confusion he has stopped saying "amen," both at school and at home. He also has learned how to use a "Crawli-gator," and travels with it quite well. J. has been placed on a chair with sides on top of wheels, to teach him the movement of his legs when walking. Although it is apparent that he understands this motion, he has difficulty doing so because of poor leg muscles.

During the past seven months, J. has accomplished almost all of the tasks presented to him, thus I feel that J. has benefited greatly from a one-to-one situation. If possible, he should continue on this basis because he is ready to achieve higher levels of development.

Case Four

Child: M., Male
Birthdate: 9-30-70
Diagnosis: Hyaline Membrane Disease
Bilateral Retrolental Fibroplasia
Vision: Undetermined

Services 1970-71:

M. was born 3½ months premature. His birth weight was 2.7 and went down to 1.9. On December 22, when his birth weight was 5.7, his mother took him home. It was only then that she discovered he was blind.

M. was a three-month-old infant when the itinerant teacher first visited the home. Since the first few times she visited, M. slept through the session, the teacher talked mostly with the mother. The mother expressed her fears and disappointments freely. She expressed an interest in the literature the teacher left comparing her baby with those in the books. She also followed some of the ideas from the book on her own and expressed pleasure when M. responded properly. The teacher encouraged the mother to use a great deal of tactile stimulation. After the third visit the baby was always awake and developmental progress was noted.

He cut his first tooth at ten months. He could roll over and enjoyed being held in a standing position but could not sit up alone. He could sit in a high chair while being fed. He liked to search for items on the tray.

M.'s mother suspected that his eyes followed the sunlight on the wall so the teacher left light-reflecting plastic panels for the mother to experiment with over the summer. Throughout the visits the teacher left toys and demonstrated their use.

Services 1971-72:

M. grew stronger over the summer and was able to do more things. He would play contentedly for long periods of time with the toys he would find about the house. His mother would put him on the floor and let him explore the items he would find. When he could finally get up to the coffee table, she kept interesting things on it. During this second year he became very shy and the itinerant teacher had to approach him with extreme caution. This became more intense and by the end of the year, whenever a stranger would talk to him, he would try to get to his mother or would scream for her. He was developing a real temper and the itinerant teacher felt it necessary to caution the mother about allowing M. to manipulate her.

M. had quite good receptive language and would follow simple commands such as "take off your socks," "roll over," and "sit up." He could point out his eyes, nose, mouth, hair, and do the same on his mother. Whenever he was placed in a new situation such as a new chair, he would explore it carefully with his hands.

He had certain toys which were favorites and he played with them in an exploratory fashion, feeling them, sticking his fingers into any holes, banging them, turning them round and round, and making noise with them in any way possible. It was observed that whenever he dropped a toy he could retrieve it instantly without having to grope for it. He could tell which direction it went and where it was. He could do this sitting and lying down. He could not yet stand alone.

He loves to be led around and on occasion will himself do the leading. He is not yet sure enough to try stepping out into space on his own.

Feeding may become a problem. He is still on strained foods and rejects anything more solid. He spits and gags and his mother will give in and return to strained food. The only finger food that he has not rejected is a graham cracker. He does drink from a cup and will hold it himself. His nighttime bottle is the only one that he expresses any interest in.

During the spring the Developmental Clinic of Children's Hospital made videotapes for teaching their staff about normal development in blind children. They taped M. After the taping his mother held him while she viewed the results on the monitor. M. cocked his head toward the monitor when he heard his mother's voice on it. He became very puzzled. The voice came from across the room, but there he was in his mother's arms. He reached up and felt his mother's mouth searching for what he knew was the source of that beloved voice, but his mother's mouth was closed. M. has spent 17 months mastering his mother's body and his relation to it, and suddenly everything was wrong. How does one explain television to a 17-month-old blind child?

Case Five

Child: R., Female
Birthdate: 8-6-67
Diagnosis: Retrolental Fibroplasia
Retinal Detachment O.U.
Vision: L.P.O.U.
Referral: Pennsylvania Association for the Blind

Services 1970-71:

R. attended the Title VI-E.S.E.A. project on "Developing Independence in Preschool Visually Handicapped Children" during the summer of 1970. After several weekly sessions with R. in her home, the itinerant teacher felt that although R. was developed mentally within the norms for her age group and her mobility appeared excellent, there were two areas that needed special attention: speech and play. Her vocabulary and pronunciation were adequate but she did not speak spontaneously. Most of her speech was echolalic and she seldom initiated conversation. She very quickly lost interest in playing. After several weeks of discussion the mother agreed that a nursery school might be helpful. A large church on the corner of their street sponsored an excellent nursery school. Arrangements were made through the Pennsylvania Association for the Blind for tuition money.

The itinerant teacher discussed the situation with the director and preschool teacher, giving them literature on blind children. A mobility specialist accompanied the child, the itinerant teacher, and the mother on visits to the room before R. actually started. No changes were felt necessary in the rooms or routine. R. started regularly in January.

An aide stayed in the classroom the first week, but her services were not needed after that. (Aide's Report Follows) The itinerant teacher visited the classroom weekly giving suggestions, answering questions, and sometimes providing equipment. Changes noticed in behavior over a period of time:

1. By April R. was initiating short conversation with trusted adults such as nursery school teachers and special teacher. These usually consisted of stating a desire such as wanting to use the sliding board, wash her hands or using the play dough. If the routine were different she would make comments that were intended to be self-reassuring such as, "Mrs. W. is home sick. She'll be back tomorrow," or "We will have juice outside today." When initiating speech, R.'s voice was soft rather than harsh as when she was parrotting.

2. R. became more aggressive in using the toys and equipment. She became skillful at riding the truck, sliding on the sliding board, walking the balance beam. Although she never made structures with blocks she spent much time getting them out and putting them away. By April she would paint at the easel and want to take her pictures home to show her mother.

3. She made great strides in mobility, seeking every opportunity to practice her technique in the many large echoing halls in the church. She was allowed to do this freely. She would stamp her feet and search for light clues to work out

a pathway and then would practice running very fast. This was a favorite activity and she became very skillful. Later when the class went outdoors to play, R. practiced using the stairway in the same way.

4. R. was able to play alongside other children although she seldom spoke to them. She liked to listen to their chatter as they played, however.

5. Because of the aide's concern about her inattentiveness and R.'s mother feeling that she "doesn't listen" and the teacher commenting that she has to be told to do something several times and then led through the motions, it was recommended that R. be given an EEG. This was arranged through her pediatrician in mid-June. The results showed Petit Mal Epilepsy and she was put on phenobarbital. Her mother reports that she is not so loud and more cooperative.

The teachers at the nursery school expressed satisfaction with R.'s participation in their program and invited her to attend next fall.

Report by Instructional Aide

Subject: R.
Setting: A preschool nursery class located in a suite consisting of a large classroom-playroom, a small playroom-workroom, and a bathroom, all of which require separate entrance and exit from the hall
Date: January 26, 1971
Time: 10:00 - 10:15 a.m.

R., age three years and five months, is for all practical purposes a congenitally blind child, although her mother reports that, during her first week in oxygen she jumped and responded by crying whenever flashbulb pictures were taken of her. However, because she is, in effect, a congenitally blind child of three and one-half, her facial expressions and gestures are severely limited —her face wrinkling and creasing when she bellows (not cries) and lighting up from ear to ear when she grins. There are no subtleties in between—no slight frown, bewildered raise of eyebrows, tentative hint of a smile. Her gestures are either those of someone swimming through heavy water or those of a robot that has been programmed through a performance. Moreover, her voice is curiously devoid of expression, being nearly atonal except for rising at the end of nearly every utterance. Even the statement of her name sounds like a question. Her voice also has a harsh, nasal quality and is always loud in volume. Her mother, a very soft-spoken, flat-voiced woman herself, told me that R.'s hearing is within the normal range although they have been warned to watch for hearing problems. Her mother also stated that R. is addressed in normal tones by those who know her and that she has one brother who has a hearing problem.

Observation I:

R. was led to a work table and seated by herself. At this point none of the other children have approached her at all, although P., a withdrawn child who wore glasses, observed her closely from a safe distance.

A lump of playdough was placed in front of R. and her hands placed on it. She gouged a piece of playdough out and, holding it with a loose-jointed grip, spent nearly four minutes

familiarizing herself with it by patting it on her face and smelling it deeply. She then dropped it to the floor deliberately and was told by Mrs. M. to pick it up. This she did with assistance from the teacher. She then continued to roll the playdough on her and smelling it. She then made finger shields of the playdough and continued to pat her face. She made no attempt to terminate this play activity herself.

While she was playing with the playdough, other children knocked over a pile of blocks and fighting broke out. R. did not jump but simply turned her head slowly toward the sound, signifying security and acceptance of the strange conditions. R. played alone, although one boy (M.) and two girls (P. and S.) came and stood within two feet of her and watched her silently She did not exhibit any awareness of their presence.

After ten minutes of this activity, R. set the playdough aside and began making washing motions with her hands. As she did this, a child made a loud car-motor sound to her left. R. again turned her head slowly to the sound but did not cry or show any signs of nervousness. At the same time Mrs. W. played the piano, blocks crashed, and children sang. R. remained at the table listening calmly.

Mrs. M., seeing that R. was apparently through with her playdough, assisted R. in cleaning up by placing a container in front of her and asking her to put the playdough in the bucket R. seldom obeys on the first instruction, but this time she obeyed on the second request and continued her task, with prodding, until all the playdough was picked up. B., the first to try to touch her, attempted to hand her the playdough.

Next, R. was given a paper towel and asked to help wipe the table. At first she made gross movements in the air. Assisted by Mrs. M., she brought her hands to the table and made a scrubbing motion in an oval shape, using both right and left hands with equal skill and results. Five other children, boys and girls, helped in cleaning the table. As yet no questions or explanations have been asked or given concerning R.'s handicaps, although the children watched her cautiously and curiously and maintained a "no-man's land," between themselves and her.

As soon as R. was excused, she moved directly to the cupboard where the blocks were kept and removed them from the cupboard, exhibiting excellent sound orientation. Mrs. W. immediately interrupted R., telling her that it was time to put toys away, make the room neat, rest, and hear music. In what for passive R. was a major objection, R. asked if she had to go home and pointed out that no one had rested yesterday. Mrs. W. did not reply, but asked if she should put the toys away herself or if R. would help. Responding to the request for help, R. put the blocks away. She used her left hand after being touched on the left elbow. There seems to be no clear-cut dominance in her hands although she does use her right foot consistently.

Approximately forty-five minutes after her mother's departure (R. was not told of her going), R. discovered her absence and began to bellow. Her crying was of short duration (one minute and forty-five seconds) and ended when Mrs. W. asked her if she wanted to wash her hands or stay with Mrs. W. R. chose to sit on Mrs. W.'s lap and cuddled against her, sucking her thumb. P. also refused to go the restroom but stood protectively close to R. When Mrs. W. started reading, the boys crowded around, brushing against R. who straightened up, removed her thumb, and smiled.

Observation II: January 26, 1971, 11:00 - 11:15 a.m.

R. was seated between two other children for the morning snack. She did not respond to the bowing of heads at the beginning of grace, but instead found her crackers with her left hand

and began eating them immediately after transferring them to her right. She was gently and kindly reprimanded and she put her cracker down and waited. She seemed very tired as her chin nearly rested on the table and she kept rubbing her eyes with traditional "sleepy child" gestures.

R. was not told that she had juice, and when she located the cup while randomly exploring, withdrew her hand as if burned. Returning with both hands held in a cup shape, she picked the cup up carefully, drank slowly, and kept one hand on the cup at all times until the cup was emptied. She then abruptly left the table while others waited until they were excused and then cleaned up after themselves. R. was returned to the table, helped with her cleaning up, and given an explanation as to proper procedure for the future. She listened attentively, head cocked to the left.

Next, roll call was taken. R. made no response or recognition of her name. Mrs. W. seated R. beside her in the story circle. R. rose and walked around and then seated herself upon command. Mrs. W. continued to hold up a storybook, giving very little verbal supplement. R. rose and began to climb the window ledge. Mrs. W. rose, retrieved R., and brought her to sit on her lap. R. smiled and repeated interrogatively, "Sit on Mrs. W.?" She sat during the rest of the story and Mrs. M. held P.

When it came time to go home, R. responded correctly to questions concerning wearing of certain clothes such as leggings, boots, and hats. She indicated anxiety and eagerness to get home by promptly, obediently, and cooperatively following Mrs. W.'s instructions in helping to dress herself. She kept asking if she could go home to see Mommy and assisted in dressing herself by voluntarily pulling up her pants and struggling into the straps. She then traveled to the coat wall, removed her coat, and returned to Mrs. W. by voice cue. During the procedure of dressing, R. laughed aloud and obeyed promptly.

Observation III: January 27, 1971, 9:00 - 9:15 a.m.

Today there were 19 children present in the class since Wednesday is a "lap" day with several schedules in effect. R. was brought to school by her mother who pushed and towed her. As soon as R. entered the door, she was grabbed by P. who untied her hat, then shoved R. back to her mother. Her mother shoved her to the coat rack where she removed R.'s leggings and coat and hung them up for her. Meanwhile, Mrs. W. placed the sleep mat in the cubbyhole assigned to R. While R.'s mother and Mrs. W. conversed, R. went in a direct line to the monkey bars and proceeded to climb the ladder-like side. She did not locate the plattorms inside the cage. After climbing to the top and hanging there for a while, she would leap into space, ignoring the procedure of descent. At all times during this activity she had a smile on her face and made soft barking noises apparently indicative of pleasure. From the monkey cage, R. followed a direct and accurate route to the cupboard of blocks signifying a remarkably accurate route memory. She then began removing the blocks methodically, clearing one shelf at a time, and placing the blocks in a random pattern on the floor, making no attempt to examine their shapes and figures as she did so. She was interrupted by Mrs. M. calling her to the playdough, and she went immediately to the same position in the same place as Tuesday. She made no attempt to vary her play activity of yesterday, but continued to pat her face and smell her playdough. However, she obviously takes great pleasure in this tactual activity as evidenced by her willingness to do it and the length of time she spends contentedly at it.

Just as she began to shred the playdough into small pieces, a new activity, the record player began to play. At first, R. remained expressionless, but then she broke into a smile and stamped her feet (no rhythm involved), something she apparently reserves for extreme happiness.

Observation IV: January 27, 1971, 10:00 - 10:15 a.m.

When it came time for the rest period, R. retrieved her blanket by herself and moved to the approximate place where she had rested yesterday. She had begun to tire as exhibited by squatting and sucking her thumb and frequent inquiries about whether it was time to rest. Prior to the rest period, the piano is played to signify clean-up time. R. rose, left her blanket, and started toward the music, smiling broadly. The music ceased. R. abruptly veered toward the toy kitchen where she began to throw toy pots and pans. This was apparently done in anger. Although her face remained expressionless and she did not vocalize, there was a great deal of force behind the throwing. Mrs. W. then took R.'s hand and was joined by P. in talking to R. and cleaning up the play cupboard. P., who is the only child wearing glasses, seems to be developing an increasing and protective interest in R.

R. broke away without finishing the cleaning up and shallowly explored a nearby play chest for the first time. Mrs. W. took her to the cleaned playdough table which R. recognized as shown by smelling for the playdough. When it was time to wash the table, R. was given a sponge. This time she placed it on the table but continued to make stabbing motions, bumping the table randomly. For the first time, the other children started to make comments such as, "Be careful—she's a new girl. We have to be nice"; "Be careful—she's a blind girl"; and "Let her touch—she can't see." She left her drying towel abruptly and was assisted by Mrs. M. to the center of the room.

The children began to play a game where questions are responded to by the stamping of feet. R. responded by stamping, but it was difficult to tell if it was an appropriate response or her extreme happiness response. I am inclined toward the latter. For the first time R. began to tentatively touch the children near her in the circle.

The next game was one where fists were pounded on the floor to simulate thunder and finger taps were done for rain. R. made no response to this game, even when sculpted into position and manipulated through it. R. rose suddenly, left her teacher, bisected the circle in a direct line for Mrs. W.'s lap, and seated herself upon it, sure of her welcome.

The next activity was singing "If You're Happy and You Know It." R. smiled broadly and chuckled aloud. Other children laughed in approval and stated, "She's happy. She likes this."

Observation V: January 27, 1971, 11:00 - 11:15 a.m.

R. began eating again before grace, but stopped herself when others commented upon it. She anticipates the routine by asking approximately five minutes in advance if it is time to start the next activity. For instance, near the end of the rest period, she kept rising to the balls of her feet to query if it were time to "Put mats away?" and "Drink juice?" She eats slowly and neatly with great concentration and care.

She refused to go for restroom duties again although three girls coaxed her to come with them. Instead she stayed clinging to Mrs. W. She promptly returned by Mrs. M. R. then placed the garbage in the paper cup and carried it to the wastebasket.

During show and tell, a once-a-week activity, R. performed her first aggressive act in attempting to wrest the bag away from Mrs. W. who dissuaded her by explaining contents.

During roll call R. did not respond to her name although she was urged to do so by the other children and teachers. The activity was postponed by a bathroom emergency on the part of a little boy, and R. took the opportunity to circle the room and explore. She marched rhythmically, swinging around the clear center of the room but always returning to the noise of the children. She wandered to the monkey bars, bouncing up the outer edge and then dropping fearlessly to the floor. She has not made any attempt to discover what is in the middle.

She again returned to the window sills and began to climb them. Mrs. M. stopped her, telling her how loose and shaky they were and that they were, therefore, dangerous. She then tested the other sills, climbing the first one that was steady, and in her mind, therefore, safe.

After resumption of show and tell, the question was asked, "Who brought this?" R. would demand tactual exploration and refused to surrender several items. She began anticipating leaving for home at 11:15.

Observation VI: January 28, 1971, 9:15 - 9:30 a.m.

R. clung to her mother today, refusing to release her hand. Her mother stated that she was so excited about coming to school that she had failed to eat breakfast and had expressed only anticipation. Her mother solved the conflict by telling R. that she would stay. R. then settled into playdough, rolling balls and shaping links, an activity she learned yesterday under teacher's instruction.

R.'s mother then asked me if she should leave. I suggested that she tell R. the truth—not saying she's staying unless she means it since this could destroy R.'s trust in both her mother and her teachers. She then offered to come and help with R. on the days that the class is crowded. I discouraged her by saying that R. would expect her every day since she is too young to distinguish which day it is. I also pointed out that this was simply not the purpose of school or the procedure other parents followed.

Meanwhile, R. had busied herself with the playdough. Under Mrs. M.'s guidance, she rolled the playdough into a long sausage and attempted to cut it with a tongue depressor. She cut it with Mrs. M.'s guidance, but only stabbed the air while on her own. She exhibited enjoyment by her persistence and concentration.

Today R. was bothered by a cough. She does not cover her mouth despite repeated aid. While in many ways she exhibits good body awareness, it is only in locating parts of her body, not in doing anything appropriate with it.

After playing ten minutes with the playdough; R. began to bellow for her mother. Mrs. M. explained that Mother had gone home the way all mothers do and that this happens every day. Another child then brought R. some tissue. R. stopped crying to listen and accept the tissue. R. then asked if she could wash and rest, apparently feeling that this would speed the return of her mother. Mrs. W. agreed to let her wash, but explained that it was not time to rest.

Observation VII: January 28, 1971, 10:30 - 10:45 a.m.

During the sing-along, R. sat on Mrs. W.'s lap and pressed her head against her, obviously contented and relaxed. Overhead, the organ which R. is supposed to fear, played loudly, but R. took no notice and did not even cock her head in her attitude of listening. She made no attempt to sing along or give any response to rhythm.

When it was time to get the mats for rest period, R. wandered into the play kitchen area and had to be redirected to the cubbyhole. She does not respond to oral direction given from a distance, but must be directed by close and even physical contact. There does not seem to be consistency in response even in familiar and standard situations.

Upon locating her sleep mat, R. spread it out and requested a Mr. Rodgers' record. Mrs. W. obliged her. R. lay quietly for nearly three minutes, and then located D., a child here for the first time today, but with whom there seems to be rapport. She pulled her mat next to D.'s with a smile, placed her arm across the small of D.'s back, occasionally smelling and stroking D.'s hair which D. accepted. The record was naming activities to fit emotions, and R. rose in an attempt to follow instructions. She was returned to her mat.

Observation VIII: January 28, 1971, 11:05 - 11:20 a.m.

During roll call R. did not respond to her name, but neither did many others. She began asking to get ready to go home. She was taken on human guide to the coat rack where she located her own clothes. Today she demanded and was given maximum assistance in putting on her clothes, refusing to even pull her leggings to her waist. The only response to a command was that she willingly used the preschool procedure for putting on her coat by swinging it over her head. She laughs aloud when she does this.

Observation IX: January 29, 1971, 9:05 - 9:20 a.m.

Entering with a smile on her face, R. located the coat rack by trailing along the wall. She did not find her particular hook until she received assistance. She began to undress herself, succeeding in removing her coat and hat and starting on her leggings. Her mother shoved her toward a chair, neglecting proper techniques. R. fell on her bottom, whimpered, rose by herself, and employed the right techniques for seating. Her mother then continued to assist her in undressing but allowed much more independence on R.'s part. R. was also assisted by P., who was absent yesterday.

After undressing, R. returned to her clothes hook, leaving the room by accident. As soon as she entered the hall, she realized her mistake, stopped, stamped her foot for sound cue, but only returned when her mother called to her and directed her. She returned with a smile on her face.

Since entering the room she has had a smile on her face and has asked no questions about Mother leaving or staying. On her way to the playdough table, she stopped at the monkey bars and discovered the inside for the first time. She made no attempt to explore them further, but continued quickly on her way. Perhaps this is indicative of her reluctance to welcome new experiences. She does not enter a new activity wholeheartedly, but must be eased into it gently and patiently.

At the playdough table, she held a large lump above the table and stabbed at it repeatedly in an attempt to recreate the play of yesterday. When Mrs. W. broke a smaller piece off, R. made no attempt to do anything but hold it. When J. suggested cutting rolls for butter cookies, Mrs. W. showed her how to break it into balls and press them flat for play cookies. She then showed her how to make a fist and pound the playdough. R. began stamping, her sign of great happiness in moments of satisfaction.

Mrs. M. came to the table and made big and little pieces of playdough. She explained the difference to R., and then R. chose the proper one on command and did it accurately and correctly.

While R. seldom responds to direct questions or volunteers information, she answered "yes" to the question of a big brother at home and volunteered that his name is D.

She investigated the scissors and responded promptly and correctly to "You have the scissors. What do you have?" She was unable to use them without assistance since she could not bring the paper between the cutting blades and keep it there.

She was then taken on human guide to the playroom. This was her first experience there. She made no attempt to explore it, although she expressed interest in the sliding board when taken to it. However, she refused a ride on it by bellowing loudly. She made a second attempt after others rushed past her, climbing up and down and squealing with pleasure. However, this ended when she was bumped by B. in the rush.

After returning to the main room for the day's clean-up, she seated herself on Mrs. W.'s lap for the group singing. She smiled and bobbed her head, but did not participate orally.

Observation X: January 29, 1971, 10:10 - 10:25 a.m.

R. and D. teamed up on the sleep blanket. R. rested quietly only rising to her knees once during a LP record. At this time, R. rose and gathered up her mat. Mrs. W. returned it to the floor and had her roll it up correctly. She failed to return it to her section of the cupboard, seeming not to hear or feel directions or touch. Since she had a smile on her face, she may have been playing a game, although I feel that a possibility of brain damage definitely is possible. She is showing increasing independence in traveling to the bathroom, but her consistency of performance in traveling is erratic and she cannot be depended upon to follow safety techniques.

Report of Mobility Student

R. was just beginning to attend a preschool class in her neighborhood when I began working with her in January, 1971. In my first meetings with her I conducted her sighted guide between her home and the church where the class was held, and demonstrated some of the techniques to her mother, who was to take R. to and from school. I also examined the classroom and its layout, in which she was to attend.

Attempting to set up a time to work with R. in the classroom, I contacted her teacher who informed me that a vision specialist was already working with R. and that my presence would allow too much confusion. After explaining to her my objectives in R.'s mobility, she agreed to incorporate some of my suggestions into her teaching plans. These suggestions were in the area of concept development: body awareness, directional concepts, relational concepts, etc., and in the use of trailing and landmarks for her movement about the classroom.

In this forced role as "advisor" I had several conversations with both R.'s mother and teacher in the remaining weeks to see how R. was adapting to and functioning in her new environment, and received most positive reports. At the end of my practicum I was permitted to observe R., and found her interacting with the other children and getting about the classroom safely and adequately using both trailing and sound cues in her movement.

Report of Nursery School Teacher

R., three years five and one-half months, entered the nursery class as a member on January 25, 1971. Prior to this she had had a visit to the class when in session with her mother and her caseworker, and one subsequent and very brief visit to the room when no children where there. On the second trip she was accompanied by her mother, caseworker, and mobility instructor. R.'s mother stayed with her for the first few days of school. After that she remained only long enough for R. to hang wraps on her hook and establish contact with a teacher.

One month after entering school, R. started moving around the room freely without teacher suggestion and began exploring doors and halls. Six weeks after entry she was able to wash her hands in the lavatory and return to the room unsupervised.

At no time has she been rejected because of blindness by any other child. She has made children angry by some of her actions and has had a very angry sounding "R. don't do that" in return. She was slapped when she took a dress-up hat off a girl's head. She has been shoved and bickered with when she wanted the same thing as another child. That same child would stop the bickering to help R. when the need arose. R. eventually rejected some of the "mothering" imposed on her by two of the girls by pushing them away. This in no way dampened their ardor. One of the boys expressed his interest in R. by trying to hug her. This was a safety problem because he hugged her around the neck. R. does not vocalize this discomfort to attract a teacher's attention.

Generally parents were surprised to learn of a blind child in class. In many cases their own child had made a statement such as "R. can't see, she's blind," then dropped the subject. Some did not mention it at home.

At the end of four months, R. was not yet playing cooperatively with other children. She had a strong drive to join groups at play but succeeded only in disrupting them. She still seemed to need familiarization with most things and had not yet reached the stage of employing them in a constructive way.

Large class attendance and much noise were more disturbing to her than to any of the other children. She wanted to be held closely by the teacher and would cling even if not picked up or held.

R. passively enjoyed songs and finger plays and actively participated in the Elephant game and Bunny Bunny (hopping).

All children accepted the few special considerations for R. (her own coat hook and place at snack table) without expecting like treatment.

R. spoke very little in January and that was parrotting what she had been told to say. By May she was initiating conversation and spontaneously expressing herself. She is not very verbal and speech does not seem to be easy for her.

Other children in the class apparently had no reaction to R. other than acceptance. They seemed to instinctively know her limitations with no outside interference. Nor did they give her more special privileges than they would accord any good friend.

We were delighted to have R.!!!

Services 1971-72:

R. attended the Vacation Bible School in the church where she had gone to nursery school. She was able to take part in nearly all activities. The teachers were all volunteers and had not received any special orientation for working with a blind child. Although there were no formal reports all those concerned were satisfied things went well.

Because the teachers at the nursery school were so competent in responding to R.'s need to practice socialization and were committed to encouraging her to become as independent as possible, it was felt that the itinerant teacher need not visit weekly. The nursery school teachers report describes R.'s progress.

In discussing future school placement with the parents, the itinerant teacher described all of the options available and the parents were very quick to decide that they would like to have R. attend kindergarten in their local neighborhood school. No blind child had attended a public school kindergarten in Allegheny County, so this would set a precedent for an educational program toward which educators in the area of the visually handicapped had been working.

Since this was a situation which needed careful preparation, a meeting was held in the office of the superintendent of the local district. Those present included the district superintendent, director of pupil personnel, the Title VI-A itinerant teacher, the head teacher of the itinerant services to visually handicapped children of the Allegheny Intermediate Unit, and the nursery school teacher who had worked with R. for two years.

Reports on R. were made available to the school officials as well as pictures of R. in the nursery school situation. The philosophy of integrating handicapped children with their normal peers was discussed and the services available to the local school district through the Allegheny Intermediate Unit were presented. It was stated that R. would be eligible for services from an academic itinerant and a mobility specialist.

Questions raised by the school district representatives were the inadequacy of the kindergarten teachers to deal with the special needs of a blind child, in classes that might be overcrowded and the responsibility of the school district in case of accident.

It was pointed out that this was a school district which prided itself on the excellence of its school system, that their teachers were carefully chosen, and that the attributes and skills necessary for handling a young blind child were the same as those for a normal child. The Allegheny Intermediate Unit would assume the responsibility for orienting the teachers in any special areas and would provide support services throughout the school year. The class size in that particular district approached the ideal and since the immediate neighborhood was losing population rather than gaining, conditions ought to improve. The nursery school had experienced no difficulty in a class of 15, and in a more highly structured situation 20 or 25 children with one blind child should not present a special problem. It was pointed out that although R. would probably fall more than other children, she was not rash or careless, that she was accustomed to getting many minor hurts and took them in stride. As far as responsibility for injury, the school should not be held any more responsible for R. than for any other child, but on the other hand they would be as responsible. The meeting ended on the very positive note of the district officials saying they would be willing to register R. for kindergarten. The parents, of course, were waiting anxiously for this good news.

Subsequently, a meeting was held at the school R. would attend. Those present were the principal of the building, a home school visitor and the school counselor. It had not yet been decided which teacher would be getting R., so no teacher was present.

Since these were the people who would be directly responsible for R., their anxieties were more obvious and direct than were the school officials. Their concerns were about the probable disruption of their program, the fear that R. would find their academic content meaningless and the proper evaluation of the child, and the feelings of the teachers in the building. The itinerant teacher felt an undercurrent of antagonism and a lack of trust in her word that these would be support services. It was felt that much orientation and work on the changing of attitudes was needed. The itinerant teacher tried to make it clear that had she not every confidence that R. could succeed she would not have proposed that she try.

The first visit with the actual teacher was much more encouraging. She seemed to be a person genuinely interested in children. She had seen R. when she came to visit her brother and that she was looking forward to the experience for herself and the children.

The itinerant teacher found two articles by kindergarten teachers who had had blind children in their classes and gave them to the teacher and principal. During the last week of school it was arranged that the itinerant teacher would bring R. to the kindergarten to visit and to give her a chance after the children had gone, to explore the room at her leisure.

Report of Nursery School Teacher

R. has now attended nursery school for a little more than one year. She has become so self-sufficient that all teachers (including one new one who had never known R. before December, 1971) are relatively oblivious to her blindness.

In the summer of 1971, R. attended a two-week vacation church school. It was not in the room she knew as her nursery school. Very few of the children were already known to her and none of the teachers—all of whom were volunteers. R. adapted quickly to the new room and equipment, children, and teachers, and still refers to that room as her "summer school."

R. has become highly verbal. She laughs loudly when she's happy. When involved in "happy play" (large cartons are a favorite) teachers have had to ask her to use a quiet voice. When another child runs into her, knocking her down, she may say, "You tripped me M." or when D. hits and/or snatches from her, she calls him by name, telling him to stop it and give back the object.

R. is used to falling and being hurt and rarely cries. If she cries, or even whimpers, it seems to indicate severe pain that should receive teacher attention.

Teachers rarely need to provide protection from other children. R. can and does take care of herself. In general, the children who were in the class when R. started school have a bit more care for her well being. The new children in September have not given her any compensation for a handicap. She has had to compete on their terms.

R. takes care of her physical needs alone—toileting, hand washing. The only time that a teacher checks on her is when she does not return to the room within a reasonable time. In every case, she had decided to visit another class to see what was going on—not necessarily to participate.

She is insistent on doing things for herself such as going down stairs. R. is vehement in her "Let me go," when she has mastered a situation. She is not rash enough to burst into the unknown.

Rearrangement of equipment makes no difference to R.'s ability to find and use it. She paints at the easel, pastes, crayons some, cuts a little, bounces and catches a ball, stacks blocks,

but has not yet progressed to more intricate constructions and is much more purposeful in experimenting with and handling material. She is more apt to participate in games than in role playing.

At this time, the outdoor play equipment provides the main concern for safety. R. uses the swings, slide and sandboxes as freely as any sighted child, but is apt to walk into the path of moving swings, glider, etc. Sighted children don't always observe the safety lines around the swing set in their enthusiasm to ride, but we have not worked out a plan that will aid R. in particular. Possibly a very slightly raised boundary would help since she sometimes checks locations with her foot.

There has been only one adverse class situation develop due to R.'s presence. It was not caused by R., nor did it appear to affect her. Without R. the other child's emotional problems would surely have manifested themselves in other ways. (Overly solicitous of and responsible for R. followed by other children's infringement of what she felt were her exclusive rights.)

The following is typical of R.'s present behavior. R. dyed eggs, using a dipper after her first attempt by hand, as she did last year. Teacher said, "We do it this way now," and she did. She wouldn't give up the eggs until the teacher told her that she could put them on a rack and touch them occasionally to see if they were dry. When she decided they were dry, she suggested they be put in a bag for her. Teacher wanted her to put one in a large basket with others for poor children (our Easter sharing project). R. declined, hesitated a bit, then said, "My mother's pretty poor, so I'll take them home to her," and she did.

Case Six

Child: L., Female
Birthdate: 2-26-67
Diagnosis: Microphthalmos O.U.
Vision: N.I.L. O.U.
Referral: Pennsylvania Association for the Blind

Services 1970-71:

This child had been known to the developmental clinic whose observations were that she was seriously disturbed and probably retarded. At 3½ years of age she could not walk, did not feed herself, could not talk and refused to play. Her characteristic behavior was to rock back and forth, bang her head, scratch and slap her face. She would go into a screaming tantrum and throw her body out stiff when persons tried to touch her. On her initial visit, the itinerant teacher only talked with her very distraught and discouraged parents because the child could not be approached. Apparently the mother had experienced a deep depression at the time of this child's birth and rejected the diagnosis and the child. Only recently had she been able to face the reality of the blindness and try to work with the child. The mother said that if L. could be taught she would be greatly relieved. The teacher demonstrated how to feed her from behind the chair, guiding her hand with the spoon. On the next visit the teacher brought a specially bent spoon and the parents reported great success. By Christmas she was feeding herself entirely alone, except for finger food.

Since L. rejected all personal contact and would not touch toys, the teacher decided to try tactual stimulation with a hand vibrator. On contact with the vibrator L. stopped rocking and making noises. She sat quietly but tensely for about three minutes while the teacher applied the vibrator to her hands. The sessions with the vibrator were continued each week as L. seemed to like it. She laughed on touch. The time that she could tolerate the vibrator lengthened with each session. The rest of the time was spent talking with the parents who needed a great deal of support. After the Christmas vacation L.'s mother reported that L. seemed to miss the sessions and indeed she became more aggressive in her association with the vibrator, reaching out for it, laughing and enjoying it on different parts of her body.

Besides using the vibrator, the teacher spent time imitating L.'s mannerisms; L. would listen very carefully and on occasion when the teacher would stop, L. would reach out to see if she were here and then immediately retract her hand.

In January, a special studies student in orientation and mobility began working with L. twice a week (Report follows). At about this time a positive change was noticed in the parents. They became more relaxed, were able to verbalize their fears and expectations and took a more active role in L.'s progress. The mother had to quit carrying L. because of a back condition and by herself taught L. to crawl up the steep stairs. This took several months and a lot of patience, but was a mutually satisfying experience for L. and her mother.

Also about this time the parents started taking L. to church. They reported being pleased with her response to the crowd. She sat quietly and listened, "singing" along on the hymns.

It appeared that after this change in her parents, L. made more rapid progress. She became more aggressive with the vibrator, ceased the self-destructive behavior, and had fewer and fewer tantrums. The mother reported that L. called to her saying "Ma" and that she always said "up"

when she wanted to be moved. The teacher observed her saying "up" and although she was truly saying it, she was not voicing the sounds properly and a stranger could not understand. With support behind her whole body L. could be induced to take few steps to reach the vibrator. She could not stand or walk alone, however. Her mother reported that she responded with pleasure to the deep voices of men and that she liked to stroke hairy arms and mustaches. She would not tolerate any other physical touch. The only objects she would tolerate were the vibrator and foamy, spongy toys such as "nerf" balls. She once ate a marshmallow because she liked the spongy quality. That was the only finger food she ever ate.

On the last visit of the itinerant teacher before summer vacation, L. stroked the teacher's arm and leaned her cheek against it. This was the first personal contact L. ever initiated with the teacher, although she had tolerated her body being manipulated for about three months.

In evaluating one year of work with L. the teacher felt that although not much observable progress was made, that considering the severity of L.'s disturbance, some progress was made in developing relationships. The change in the attitude of the parents was most dramatic and the teacher felt that this will be a positive factor in any future progress that L. might make. The teacher sees a need for psychiatric service, more development of a relationship and even some formal contact with a group of children. None of these had been available to her because of the complexity of her handicaps and her behavior.

Services 1971-72:

L. did not appear to have made any progress over the summer and was continuing in her bizarre behaviorisms. Her mother seemed dejected again and needed all the support that the itinerant teacher and social worker could give her. L. rejected the vibrator when the teacher tried to use it again. In an effort to get her off the couch and into some other position that might be satisfying, a rocking horse was tried, but L. was completely hysterical after many attempts. She also would not tolerate a jumper. In desperation because nothing seemed to work, the teacher decided to try to force her to walk, hoping that if L. could become mobile some program might accept her. A series of weekly walking lessons was begun which were very hard on everyone—L., the teacher, and any observers. L.'s body image was so poor that when stood in an upright position, her posturing was grotesque, and then she fought every step. This child, who could not tolerate people touching her, or who could not herself touch objects, was being forced to do it in order to walk.

She tried to pull herself away from the teacher and when she succeeded would land on the sidewalk, which she could not bear to touch. We walked outside because the house was so tiny she would throw herself against furniture. When the teacher held on too tightly for L. to throw herself loose, she would pull up both her feet and leave herself hanging in the air. She kicked and screamed, arched her back, threw her head back, and constantly blew mucous in a spray from her nose. This continued as long as the weather was good. By winter she had learned to take steps forward, but still under protest. The teacher began to substitute a stick for her hand and L. began to settle down somewhat. The furniture was moved to clear a space and the teacher brought a weighted cart which L. would push across the room by herself, screaming all the while.

Meanwhile the parents began to think about school for L. since she was going to be five in March. An appointment was made for them at the Western Pennsylvania School for the Blind, but during the interview L. did nothing but lie on the floor, scream and scratch her face and arms. The itinerant teacher visited a very depressed household the following day, and found L.'s arms and face covered with self-inflicted sores.

As a result of the refusal by the Western Pennsylvania School for the Blind, a meeting was held at the Developmental Clinic with their staff, the social worker, the itinerant teacher, and the staff from W.P.S.B.C. It was brought out that unless L. improved greatly there could be no hope of her attending the residential school as it was set up now. If they would receive some special federal funds for research purposes, she might become an interesting research project, but even that would require changes in their physical plant. It was advised that the parents begin to think seriously about institutionalization of some kind. The Developmental Clinic said they would take the responsibility for discussing this with the parents.

In December, a third aide was hired. Because of the exceptional training and warm personality of this aide, the itinerant teacher thought she would use this aide to try to develop a personal relationship with L. This was an area where L. was distressingly retarded. She had never been able to develop a loving relationship with her mother and, therefore, with no one else. She was very much alone in her sightless, unfriendly world. The role of the aide was to somehow, however she could elicit responses from L., make it be known to L. that she was her "friend," that they would do only what L. wanted to do.

The aide sang to L., she mimicked her, and she talked to her. In two months L. allowed the aide to touch her. From then on, rapid progress in understanding was made. (The Aide's Report follows.) L. learned to respond to simple commands. She would indicate her wishes by shaking her head yes or no. She played simple games and toward the end of the year actually craved being held and cuddled. She laughed out loud and smiled often while the aide was playing with her. She stopped hitting and scratching herself and her sores healed up. She learned to point to her eyes, nose, mouth, and ears. She would lift her foot and sometimes touch it on command. Her mother was disturbed when she began to masturbate at about this time. The itinerant teacher, however, felt that this was an improvement over scratching and hitting herself, and L. would stop it on command. Also toward the spring, she began to stop some of her grimacing and posturing. As her facial muscles relaxed, she seemed to become a prettier little girl.

In January another aide became available, therefore, three mornings a week were open. The itinerant teacher was able to interest the McKeesport School for Retarded Children in accepting L. on a trial basis as long as an aide could be with her. By that time, L. could walk by herself holding onto an adult with both hands for support. She could not stand or walk alone. The staff at the school was very interested in opening their program to multi-handicapped children and are equipped to be quite supportive. There were seven children in the class that L. would be in, and there was a volunteer with each child. The teachers ran a highly structured program of group experiences and individualized instruction. There was a speech therapist and a special room for gross motor activities.

It was anticipated that L. could probably tolerate being in the classroom for only a short time and severe tantrums were expected. She surprised everyone by being very interested and tolerated being led through the activities by the aide. The aide kept careful progress notes. The director of the school was so pleased with her progress that she has accepted L. as part of the program, and is planning special experiences for her during summer school.

The director of the school informed the itinerant teacher that the progress L. had shown more than justifies their accepting her and that they were anxious to have her as a full-time student next year. She was also pleased with the way the parents had responded at their parent meetings.

Report by Mobility Student

When I first began working with L. she would not respond to my voice, and invariably rejected my touch which she demonstrated by a tantrum-like action, writhing on the floor and making guttorial sounds. The only positive reaction which I observed while working with her was when I turned on the vibrator, but by coupling the vibrator with speaking to her and touching her back of head, by the end of the time she would allow me to pick her up and carry her; hold her hands, arms, feet and legs; and would respond as I came in and began talking to her, and would follow any simple command I told her to do.

Since she was immobile, my program for her was to increase flexibility and strength in her muscles needed for walking. Since I knew she would respond to the vibrator I used it as a reward for any desired response. As I continued to work with her I gradually increased my demands and lessened the time the vibrator was on; by the end she would do two or three movements, and was rewarded with vibrations for approximately three seconds. I attempted several times to omit the vibrator and only use verbal praise and touch her back, but she would not continue to respond to this. Her tolerance of me greatly increased in my time with her: at our first sessions she became irritable after fifteen minutes, and at the end she would work continuously for over an hour without displaying any adverse action.

Mr. and Mrs. C. were most interested and cooperative in L.'s progress, incorporated my suggestions in dealing with her, and worked with her in some of the exercises I demonstrated to them. By April L. had developed considerable strength in her legs, was able to crawl up the stairs with some aid, and was less objecting to new situations and devices which I initiated.

The program followed generally this sequential outline, and was introduced over 26 sessions with her:

A. In Crawling Position

I placed the vibrator on a crawling device made by Creative Play Toys and placed L. on the vibrator in a crawling position so that her abdomen rested on the vibrator and her knees rested on the floor.

1. Extension of Knee

With knee flexed and resting on the floor, I picked up one of her feet and had her pull it from my hand; progressed to my holding both feet and having her pulling both from me, simultaneously.

2. Flexion of Hip

With her legs out behind her, knees slightly flexed, and both knees and toes resting on the floor, she had to pull one knee up so that it would touch the vibrator; progressed to her pulling both knees up simultaneously.

3. Flexion of Knee

With knees remaining on the floor, she had to pick up one foot and "bang" the floor; eventually she would lift the foot I would touch.

4. Flexion of Hip and Knee

Holding her legs up and straight out behind her, she had to pull both from my grip.

B. Bicycle

I strapped L.'s feet to the pedals of a tricycle and rode her along the sidewalk. At first she objected to this, but finally grew more tolerant.

C. Walking

1. L. would stand and hold on to the back of a chair, and as her mother pulled the chair across the room I would manually move her legs in a walking fashion.
2. Looping a belt behind her back and under her arms, I walked her about the room, using the belt as support. (I used this method only in my last two sessions with her, and she still was severely objecting to this approach.)

Report of Instructional Aide

I first met L. on November 2, 1971. I arrived at the home simultaneously with the itinerant teacher, who introduced me to the child. She was sitting on the porch with her mother, and smiled when she was told she had company. She was sitting on her hands, with her head down and her back and shoulders slumped, her characteristic posture when sitting still. The itinerant teacher helped her stand and walk a little, though under great protest from L.

Following the walking, we all went into the living room, where L. pulled herself up on to the couch and into a sitting position and then began to rock back and forth from the waist, rhythmically, sitting again on her hands and rather forcefully bumping her head on the back of the couch. At times the couch even "jumped" from the force of the rocking-bumping motion. The itinerant teacher sat briefly with her, talking to her gently and applying a hand vibrator to various parts of her body, naming each in turn. L. smiled during this procedure and seemed to enjoy it. Finally L. dropped off to sleep, and the itinerant teacher, the mother, and I moved to the dining room to arrange my schedule.

I saw L. five days each week. Monday through Friday, except when I was tapering off before Christmas and before the end of the school year. In the beginning I worked with her on Monday, Wednesday, and Friday mornings, and Tuesday and Thursday afternoons, but that schedule was modified to five afternoons a week after L. began school. The visits lasted between twenty minutes and an hour and a half, with the average being about an hour. I usually worked with L. wherever I found her: on the couch, the big chair in the living room, the living room floor, or the stairs. The one exception to this was the dining room table. If she was still eating when I arrived, I waited until she finished and then we moved to the living room, where there was more freedom of movement.

I always assumed that L. could hear and understand everything said within earshot, though I could not be sure of this in the beginning.

The First Stage:

My work with L. falls rather naturally into two temporal periods, the first being from the beginning to the end of January, the second from that time to the present.

My first meeting with her, on November 4th, set the pace for those to follow for quite some time. When I arrived, L. was coming down the stairs, one at a time, on her seat. I said

"hello" to her, and told her that I knew she would be down when she was ready. Then I talked to her mother until she was almost down. When L. was almost at the bottom of the stairs, I went into the living room, read a magazine, and sang a little. I saw her smile as she sat on the bottom step listening to me hum.

I went to where L. was sitting at the bottom of the stairs then, and began trying to establish contact. I noticed that she made clucking noises with her mouth, and I began imitating the noises. When she clapped, I clapped, and was reassured of her ability to understand when I would ask if she could clap if I clapped, and she imitated me, smiling. She also stamped when I stamped, seeming to prefer her right foot. I also began to touch her at the first meeting, as I felt that a good deal of her future lay in being able to feel and touch and be touched. I touched only her feet and ankles at first, because it seemed to me that, protected as they were by shoes, her feet might be the least threatening place to start.

The meetings that followed were along the same lines as the first, with a few elaborations. I worked as much as possible on the floor, because there L. did not have the option of withdrawing into rocking and bumping her head, though, by the same token, when she lost her temper, she bumped her head fiercely on the floor.

When we were on the floor, I tried to sit with my legs spread apart, one foot on either side of her body. That gave her access to my body to feel, and enabled me to touch her occasionally with my feet, which she accepted more readily than being touched with my hands. In this position I could sing songs with a beat and rock from side to side, catching L. in the rhythm with my feet. Music, in fact, proved to be one of my most valuable tools. If I found L. in an upset state of mind, I could often sing soothing songs and calm her, at least to some extent. And when I sang more lively songs, I could begin to touch her body, as I could not when I was not singing.

Shortly after I began working with L., and realized she could respond to at least simple things I said, I began to introduce an element of freedom of choice into our sessions. If I began to feel that she was tiring, I would ask if she felt it was time for me to go. I would tell her that if she did feel I ought to go, she could move her feet; and if she wanted me to stay, she could clap. Usually she would respond one way or the other, and I told her that if she did not respond I would leave. When that system began to diminish in communication value (i.e., when L. did not respond more often than she did) I took that as an indication that it was time to introduce something more flexible, so I began to teach L. to shake her head "yes" and "no." It was slow going at first, but within about two weeks of being taught, L. began to respond about half of the time, at least to me. It took her a couple of months to begin to respond with the same to her parent's questions.

All of my work with L. during what I am calling the first stage consisted of variations on the methods described above. How much singing, how much clapping or noise-making, how much touching, etc., depended on how both of us were feeling each day. Many days I pushed too hard, or L. was not disposed for some reason to cooperate, and there were copious tears, tantrums, and head-bumpings on her part, and frequent feelings of discouragement on mine. But I guess one of the marvels of human communication is that a little bit serves for great encouragement to persist. And persist we did.

As time went on, I spent some time talking to L. I touched each part of her body, told her its name, and then told her that every person in the world was built on the same plan and had a body just like hers: a foot, hand, etc., just like hers. I also told her what I would call "The

Story of L," and I would just talk about her, and her house, and her family, etc. She smiled at the sound of her own name, and usually listened to the story attentively.

One other thing I might mention in this first section is my observation of the reaction of the mother. I never felt at ease with her, from the first day I came to work with L., and at times I even felt she was angry with me or dissatisfied with my work. One problem seems to me to have been that she often expressed interest in seeing "instant" success. She seemed to feel that since I was coming every day, results should have been more rapid and pronounced than they were. Some days she hardly spoke to me.

The Second Stage:

If I were to choose a turning point in my work with L., it would be Tuesday, February 2. I had been working with L. for about two weeks, after returning from Christmas vacation. My first day back had been most pleasant; the two weeks following, anything but that, being characterized by tears, anger, and inattention on L.'s part, and impatience on mine. Past experience had taught me that such a long period of difficult days probably meant that things would soon change for the better, but I felt as though her mother might give up in discouragement and ask me to stop coming in the meantime. (One day late in January, I had arrived at the house and had gotten no response to my knock at the door. I later learned that the mother and L. had been at home, but that the mother had decided not to let me in.) I felt tension mounting, and felt I was running a race against time.

The last Thursday in January, L.'s social worker called while I was there, and in the course of her visit she came into the living room to greet L. She said "hello" and touched L. on the shoulder. L. had been unhappy all afternoon, and at the social worker's touch, she cried even harder, but she also, vehemently, shook her head "no." I immediately assured L. that since she had made it so clear that she did not want to be touched, the woman would not touch her, and the social worker immediately picked up the cue, withdrew her hand, and assured L. that that was so. I felt that this incident was a great confirmation of my credibility, as this was the first time that L. had so clearly and definitively expressed herself to someone other than me or a member of her family, and I was grateful for the social worker's support.

The following Tuesday, I began singing and touching L. in time with the music. She responded with the first hearty laughter I had heard since before Christmas, and really enjoyed it when I tickled her in the ribs and the stomach. Then, quite spontaneously, she reached out and felt my face, and put her hands around my neck and hugged me. Except for having occasionally felt my legs at her side when we sat on the floor, this was the first time L. had reached out for me voluntarily. And that symbolizes what to me, was the primary difference between the first and second stages. During the first, I worked and gave, and L. accepted it or not, but did not respond or give of herself. After this time, L. began to be able to give back, and voluntary communication began to go both ways. She had been primed enough finally to be able to let her own self flow a little, and the difference it made in the temper of our sessions was amazing.

For one thing, I found it fairly easy after that time to help her change her feelings, especially if she was feeling dull or inattentive. I would ask her in a laughing tone of voice if she was doing nothing just to tease me, and usually she would laugh and pay attention again. I also found that if I greeted her in a teasing tone of voice, I could begin the session on a pleasant or laughing note as often as not. L. seems profoundly sensitive and responsive to tones of voice.

After this time, too, it began to be possible for L. to play simple games with me. The first I invented, and one of her favorites to this day, I called "All Quiet." It is modeled on the "peek a-boo" games every child plays. I would sit touching some part of L.'s body (she quickly came to allow herself to be touched after her initial touching breakthrough), and then I would pointedly and deliberately let go, saying as I did so, "I'm moving back now," or the like. Then I would slowly chant, "All qu-u-i-i-e-e-t . . . where's L? I'm not touching her, so I can't feel her. I won't know where she is until she makes a noise and calls me. Where are you, L.?" L. would sit and squirm and wiggle and smile and finally make some kind of sound, at which time I would call "There she is!" and pounce on her, hugging and tickling her, and she would laugh delightedly. I always insisted the sound be preverbal, as it were, rather than a clucking or otherwise nonverbal sound. If she did not respond within a reasonable time, I would "look for" her and finally find her, but that was rarely necessary.

L. also enjoyed playing catch, and her aim is now so good that she is able to throw the ball with her right hand in such a way as to be able to hit a noise-making toy, after I have only sounded it once to give her an idea of its location. She learned to put the ball down beside her when she was through playing, and can throw with either hand, though she prefers the right.

During this time, I began to hold L. in my lap. It is my feeling that she needs a good deal more of this, and with a person to whom she can become attached. When I began to hold her, she would only allow it if we were on the floor in front of the couch. She would lie across my lap, with her head on sofa pillows, and her hands beneath her body (usually) resting on my legs. She would not lie close to my body, and often pushed it as if to push it away. Later, toward the end of my time with her, L. would snuggle into the crook of my arm close to my body as she sat on my lap on the couch. Several days I felt she would have sat like that for the whole hour, had I let her.

Other things L. was able to do, especially toward the end, included clapping her hands to songs like "This Old Man," taking her hands and rocking back and forth with her on the floor to "Row, Row, Row Your Boat," crawling with my hands up her legs to her stomach and then tickling her stomach (one of her VERY favorites) and teaching her the various parts of her body and then asking her to move or point to them one at a time. A number of these things were probably encouraged by her school experience. During this time, too, she more and more shook her head, especially "no." ("Yes" is a very brief nod, and often I had to ask her to repeat it in order to be sure I understood what L. wanted.)

Occasionally I walked with her, but only at her request. Almost every day I spent some time with speech, and made sounds or said simple words for L. to imitate. This was only moderately successful in terms of response, but I persevered because I felt communication was of primary importance and this little exercise gave me the opportunity to remind L. that people can only get what they want if they are able to ask for it in terms that other people will understand. I also did an exercise where I would put my head or hand close to L.'s face and encourage her to push it away if she did not want it there. During the time I worked with her, I told L. the time was hers and she could do anything she chose except hit herself. She never overcame the habit entirely, but she did seem to do it less as time went on.

The second stage sessions were composed chiefly of combinations of the above activities, and were characterized by far more active participation on L.'s part. During the last six weeks, I little by little mentioned the fact that I was going away and would not be back, so I feel that at the time I left she was as well prepared for my going as possible under the circumstances.

Remarks:

I enjoyed working with L. enormously. Apart from the satisfaction as being a part of her emerging humanness, I enjoyed her as a person from the beginning. I would like now to make a couple of observations based on my experience that did not seem to fit naturally above.

I feel that L. is very sensitive to phraseology and vocabulary and her response to a suggestion is often influenced by the way it is presented. For example, if I would say, "I am going to pick you up," L. would squirm and cry, but if, seconds later, I would ask, "Would you like to sit on my lap?" she would be all smiles. She responds negatively to the word "love," especially as in "I love you," by whimpering and squirming, but "I like you" elicits a more positive response. L. does not like to "touch," but will occasionally "feel." And I could go on and on.

L. seems to enjoy the song, "B-A-Bay," which I sang to her often, inserting her name in the chorus. I learned it from the Limelighters record, "Through Children's Eyes."

L. seems to have two kinds of happy-excitement responses. One involves shaking her head from side to side and shaking her hands in the air at shoulder level, in rhythm. The other is an all-over shaking-squirming-stiffening, that is reserved for major accomplishments. I usually try to follow up on whatever caused the latter, but the former is often an indicator that it is time to move on or at least break the routine momentarily.

I have heard L. say words that sounded like attempts at the following: "Mommy," "No," "B-A-Bay," "Beep, Beep, Beep," and "Hi."

From early in my work with her, I have called L. my "friend," and that is a word that seems to please her, and works far better than "teacher."

I have often used language rather carefully to communicate specific aspects of situations or feelings to L. For instance, in an effort to help her free her hands I would ask her if she would like to play "This Old Man," a clapping game, and when she shook her head "yes," I would say, "All right, then give me your hands," and L. would often at least begin to do so before I took them. I think the idea of giving hands was new to her (as opposed to having them taken), but it enabled me to play with her hands with far less resistance.

I also, after I learned she had some few words, began to speak in terms of when she decided to talk, rather than when she learned, though I have no indicator on which to base a guess about the possible effectiveness of that distinction.

I enjoyed L. and I enjoyed working with her. I am happy I had the opportunity to know her.

Observations:

February 29, 1972

(My first day alone with L.)

First hour L. behaved satisfactorily. Listened intensely to children around her. During circle activities she became restless (appeared to be tired). Took one tantrum after another. L. willingly drank all her juice.

March 1, 1972

L. really impressed with little Radio Musical Box. She smiled and laughed aloud. Seem to enjoy circle activity. During this time she reached out for my hand. Changed her diaper—made with joke about my cold hands. L. laughed about this. Good humor! Shortly after took her outside for walk. Not happy about this. Started tantrum. Refused juice. Scratches her left arm and bites fingers when upset.

March 3, 1972

No school – snow

March 6, 1972

L. becoming more interested in what's going on around her. Good humor today. Permitted me to guide her hand briefly with crayon. Accepting personal contact by other children (gradually). She let me guide her hand around to feel book, cradle, and doll. Happy in circle—participated somewhat.

Likes being tickled and joked with while changing diaper. Made more sounds today than usual. Laughed and smiled today more than I had ever seen her do. Refused juice first time—then I discovered by making a gargling or slurping sound amused her—she drank three-fourths of her juice. Good day! Did very little resisting.

March 8, 1972

Mother predicted L. might become tired due to lack of rest. Amused her with toy clown and musical radio. Reacted by laughing out loud. Became restless. Combination of laugh and cry. Seemed contented enough at circle time. Refused juice and cracker. Quite fussy!

Better humor after rest period. Walked her to music room—settled down. Behavior much improved than before in large, music room.

March 10, 1972

L. arrived irritable this morning. Momentarily amused by toy clown. Permitted me to read a book aloud to her. Guided her hand in turning pages and touching book. Suddenly went into a crying tantrum. Continued for a half hour. Forced to remove her from circle because of distraction to other children. Decided upon nap. After nap responded much better. Drank most of her juice. While changing diaper noticed soreness and redness. Applied lotion. L. very settled in large music room. Let her kick ball in sitting position. Kept throwing ball in lap. She did not object.

March 13, 1972

L. arrived feeling very low. Not responding much. Cried almost continuously. Her behavior not such as tantrum-like action, but honest to goodness crying. We discovered a yellowish looking blotch in roof of L.'s mouth. Because of her reaction a decision was made to have mother pick her up so L. could be taken to a doctor. (Mother called to inform me blotch on L.'s mouth turned to be cereal and banana.)

March 15, 1972

L. very cooperative today. Gave me impression she accepted being here. Allowed me to caress her during nap time. She definitely responds whenever I playfully tease her. Participated in some circle activities (with my help). Also responded exceptionally well in music room. Showed much interest in ball. L. had two helpings of juice. A very rewarding day for me!

March 17, 1972

L. enjoyed playing with toy clown. Never seen her laugh so heartily. Becoming more adjusted to routine. L. very peaceful during rest period. Drank two helpings of juice. No resisting. Noticed she is becoming use to personal contact by other children. At P.M. time the instructor had L. on skate board. Reacted satisfactorily. Also had L. on mat for exercises. Became very upset. Succeeded in settling her down.

March 20, 1972

L. continues to respond favorably. Drank two helpings of juice. I tapped the cup to let her know juice was all gone. She reached out to do same. At P.M. time I had L. walking while holding on to soft plastic rod. Hugged the ball. Becomes upset when placed on skate board and leg bicycling. Basically, pleased with results. Decided cutting down on time in P.M. room.

March 22, 1972

L. continues to respond. Drank all her juice. (Reached out for cup for more.) Holding on to cup with my help. Enjoyed her music period. Had her hopping like a bunny (with my help). She loved this. Left school in exceptionally good humor. Making many new sounds.

March 24, 1972

L. very disturbed today. Unable to calm her down. Nothing unusual occurred to cause this reaction. Combination of being tired and stubborn. Forced to send her home. Mother said L. fine after she got home.

March 27, 1972

L. appeared to arrive in happy mood. Played enthusiastically for about 45 minutes. Became restless—ended up being so irritable forced to remove her from room. Took her upstairs to large lounge. Rolled all over floor with tantrum-like actions for one hour. During this episode she did stop long enough for three mouthfulls of juice. Continue tantrums. Tried change of scenery. Nothing helped. Telephoned mother shortly before dismissal to pick up L. She became restless same time as before. Scratched and bit herself to point of bleeding.

March 29, 1972

Arrived in good humor. L. sat in huge bunny's lap for 15 or 20 minutes. She felt fur on bunny without help from me. Shortly after became restless. Started tantrums—forced to move

her to lounge where she continued tantrums. Tried nap, soft music, humoring, caressing—no success. (I decided to take firm stand by administering a slight spanking and firmness in voice. At this time she snapped out of it.)

L. rested awhile. Drank juice. Ate one cookie (first time she accepted finger food). Left door opened to lounge while Easter play going on—she listened. Very contented in music room. Good for remainder of day.

April 5, 1972

When L. arrived kept pulling away refusing to enter room. Had to be forceful. Played for about half an hour, became restless. Started usual tantrums. Had to remove her from class. Went off to another room with her. I was very firm with her. Let her know I wasn't giving in to her. Settled her down. Returned to classroom.

Good at rest period. Drank all her juice—ate one animal cracker. Cooperative in music room. Left school in good humor.

April 7, 1972

L. very well adjusted today. She appeared to be very relaxed. Listened very carefully to children around her. Held doll and felt her hair. Good in circle. Drank all juice. When I offered L. cookie she playfully spit it back out and would laugh. Repeated this over and over. (Itinerant teacher and student teacher here at time.)

At P.M. I tried skate board and few other exercises. L. became tired. L. slightly upset. Discovered little rocking chair quieted her down. Played children's record while she rocked back and forth with rhythm to music. L. seemed to enjoy this. A good day!

April 10, 1972

L. received first speech lesson today. Reacted satisfactorily at beginning then became unbearable. Refused to respond on several sounds. Teacher insisted L. cooperate. L. finally did try to make the sound teacher was after. Settled down. Drank all juice. Refused cookie. Became slightly upset in P.M. room over routine of exercises. I use the little rocker for L. whenever she becomes upset—quiets her down. Enjoys rocking to rhythm of music. L. very pleasant at departure time.

April 12, 1972

L. escorted to room by another aide today. L. behavior normal. L. using hands to feel more than usual. Made many more sounds. Drank juice. Continues to spit out cookies (tried all kinds); actually she playfully spits it out—makes only laughter. In P.M. room L. went through motions of rowing a boat. L. doesn't seem to tire as easily. Loves music.

April 14, 1972

All the children assembled in auditorium for dental program. L. refused to permit dentist to check teeth. She did sit quietly through dentist speech and cartoon. Drank juice. L. drank

four or five swallows of water. She made a face and shook head showing her disapproval in taste. L. appeared tired in P.M. room. During flag salute L. stood alone with aid of plastic rod for about four or five seconds.

April 17, 1972

L. very cooperative today. Drank small amounts of water. Drank all her juice. Held on to plastic rod for support during complete flag salute.

L. still doesn't respond to exercises. She gets fussy, but nothing like before. Rocking chair always settles her down.

April 19, 1972

L. arrived very tired. Kept pulling away from me to keep from entering classroom. Forced her to walk. Settled down briefly. I have made much progress with physical and personal contact with L. Had her standing alone while supporting herself with plastic rod. Stood during flag salute and singing of hymn. L. became restless. Regardless as to how restless she becomes L. always drinks her juice. During P.M. time L. reached out twice to feel musical sticks.

L. became irritable. Crying real tears—very upset. Rocking chair or music did not completely satisfy her. Scratching herself (hasn't done this for awhile). Very upset at dismissal time. Her mother said L. has been off schedule at home. L. kept repeating, "Da-a" (Dad).

April 21, 1972

L.'s grandmother escorted her to school today. Held L. in my lap today for half an hour. She willingly permitted me to caress her and sing to her. Very contented during this time. L. kept running her hand up and down my arm while I held her. Continues to stand alone with slight support of plastic rod. Became fussy, but able to settle her down. Only drank half of her juice today. Responded rather well remainder of day.

April 24, 1972

I held L. in my lap again today for about 15 minutes. She nestled up very closely. Became upset at coloring time. Was able to calm her down. Refused juice first time—tried again later—she drank all. I broke off bits of an orange gum slice of candy, she chewed all of it. In P.M. room I tried skate board again with L. She responded overwhelmingly. She held on with both hands and smiled happily as I pushed her around the room for 15 minutes. (Skate board always terrified her before.) We also played with the bean bags—kept throwing them back and forth to each other. A very rewarding day! (First time L. left P.M. room in good spirits!)

April 26, 1972

L. made many sounds today—such as "horse," "apple," "Da." L. continues to let me hold her in my lap while I talk and sing to her. Became restless during circle time. I tried playdough with L. She did reach out to feel dough, but not too impressed. She became irritable. Refused to respond remainder of day. Refused juice. Nothing more accomplished today.

April 28, 1972

L. in excellent mood today. She drank some water. Started "potty training" today. L. sat very well on "potty chair." Drank her juice. L. ate some cherry candy. Kept asking for more by lifting head, opening mouth with a grunt. L. responded perfectly in P.M. room.

L. has learned to like skate board. Pushed her all around the room. Walking longer periods with aid of plastic rod. Last several days L. is exploring by feeling with her hands. She held a bean bag and kept running her hand over it. Also during nap time she kept feeling the rug until she found edge, then she would turn up the edge of rug. L. held playdough much longer today. She kept squeezing it. Not a bad sound from L. today; today tops them all.

May 1, 1972

L. had another good day. Continues to respond to routine activities. Taking more interest in feeling objects around her. Today she chewed and enjoyed a piece of sticky candy. Drank her juice. Ate a Ritz cracker. Very happy in circle. She likes to swish around in water while washing hands at sink. She responds good to learning different parts of her body.

May 3, 1972

L. in exceptionally good spirits today. She responded very well to different sounds I wanted from her. She reached out to feel objects we were working with and even held on to them longer than usual. Permitting other children to come in contact with her without fussing. Had a birthday party today. L. ate one whole cupcake. She really enjoyed it. She did not object while I placed a party favor hat on her head. She wore this home.

L. responded good in P.M. room. She held on to a musical stick for the first time. She laughed very happily while I helped her jump up and down to a game. Continues to sit on "potty chair," no results as yet. Shakes her head "no" whenever she objects. Left school in a good mood!

May 8, 1972

L.'s walking has improved tremendously. She walks with very little support from me. Wish to stress the fact that L.'s arm and finger were all healed up from her discontinuing tantrum. When she returned to school today noticed her arm and finger were badly scratched--fingers and thumbs also were badly biten. This had to happen at home. Hasn't been here at school for four days (no school Friday). L. very well behaved until P.M. time. All she wanted to do was lay down on mat. Was able to get her on skate board for awhile. L. ate and chewed a half slice raisin bread today. Continues to drink all her juice. L. reaching out frequently in search of toys, etc., while we are working or at play. Her facial expression seems so much more relaxed.

May 10, 1972

L. beaming all over when she arrived at school today. Very cooperative in our daily routine activities. L. "urinated" on the "potty chair" today. She seemed very happy about this. I really fussed to let her know how pleased I was. L. very restless in P.M. room. Refused to respond. Became settled once we got back to classroom.

May 12, 1972

L. arrived in happy mood today. Mother's meeting here at school today. They were permitted to come into our room to observe their children. L. continued to respond for me, knowing her mother was there. L. walking continues to improve. L. held onto her drinking cup longer than usual. She enjoys her snack time. Trying to get L. to hold her own cookie. She is showing improvement. A good day with L.

May 15, 1972

While holding L. today she kept running her hand up and down my arm. L. reached out so I would pick her up on my lap. L. had a "B.M." on "potty chair." A first for her. Let her know how pleased I was. Took her outside for walk. Behaved satisfactorily. Drank all her juice. Letting her hold cup when it is almost empty. L. ate a piece of coffee roll and a soda cracker. Helping herself fairly well. L. fussy in P.M. room, would not respond. She appeared to be tired. Settled down. No problem.

May 17, 1972

L. pulls herself up when I want her to stand. She does it very well. She uses her legs to support her weight then pushes herself up once feet are flat on floor. L. has acquired habit of using hands to feel for chair before sitting down. Doctor and nurse came to visit children today. L. very interested with the surroundings today. Very good humor today.

May 22, 1972

L. returned to school today in high spirits in spite of fact of being absent since 17th. Her mother has been walking L. from car to school. At speech time L. tried to make a few animal sounds for me. L. excellent during circle time.

She stands practically alone during flag salute and singing of hymn. With my aid, she handed Bible to Mrs. S. L. "tinkled" on potty. L. enjoys sitting on potty. She keeps running her hands over it. Knows purpose of potty, I'm sure. L. permitted one of the other children to hold her hand and feel her hair. L. drank all of juice—but today she refused cracker and candy.

L. upset in P.M. room. Appeared to be tired. Managed to get her on skate board. L. made many new sounds when upset. (Like she was trying to tell me something.) Mrs. C. also noticed this. Returned to nursery room, where she settled down, but every now and then would make a rejecting sound. L. walking much better—only support I give her is my finger and I guide her. L. left school in a good humor.

School dismissed for summer on May 25. L.'s arms and fingers are beautifully healed up—she no longer scratches or bites herself.

L.'s parents are very pleased with the progress L. has made over these past few months. Have never seen L.'s mother so happy—it really shows.

Chapter V

IMPLICATIONS

The results of studies conducted with visually handicapped preschool children have demonstrated the devastating effects of sensory and social deprivation without intervention at an early age. In 1957, Norris wrote:

> The failure to provide the essentials for healthy development may result in grossly retarded functioning and extreme emotional problems which do not lend themselves well to treatment.
>
> There is increasing recognition that many blind children who have been committed to institutions for mental defectives could have developed adequately if conditions had been more favorable for their development.

This statement was made as a conclusion from her work with children suffering from Retrolental Fibroplasia. These blind children were, in the main, otherwise normal healthy youngsters.

Today, fifteen years later, we are facing an even more critical problem than that of Retrolental Fibroplasia. Advances in medical science which are keeping more children alive; the prevalence of diseases such as Rubella, coupled with environmental hazards such as pollution, alcohol and other drugs; and possibly even advanced medications, have resulted in a population of complicated, multi-handicapped young children. Special Education today must address itself to the educational problems of children who could be visually handicapped-retarded, blind-autistic, mentally retarded-emotionally disturbed, hard of hearing-visually handicapped, and many other combinations of handicapping conditions. It is all the more true today than it was fifteen years ago, that early educational intervention is a necessity if these children are to reach their full potential.

The problem of appropriate preschool educational intervention raises questions concerned with the transportation, staff and expensive facilities which would become necessary if classrooms were to be provided for these children. In addition, many of these children have severe emotional

problems accompanying their physiological disorders, and removal from their homes for instruction could defeat any benefits they might receive. The itinerant teacher who works in the home with the child not only minimizes this emotionally traumatic separation, but becomes more effective in her work as she trains parents and paraprofessionals to continue her instruction in a consistent manner.

The recent court decision which must be implemented in Pennsylvania concerning children who may previously have been excluded from educational services, poses for Special Educators the responsibility for establishing educational procedures for many severely involved children who are operating at the preschool or at least preacademic level. The successes demonstrated by the two-year itinerant teaching program for visually handicapped children conducted by the Allegheny Intermediate Unit No. 3, particularly with those children who were prepared through this educational intervention to enter existing school facilities, clearly demonstrates the effectiveness of such a program. The use of paraprofessionals to extend the contact time of the teachers has proven successful. The economic efficiency of the itinerant program has been demonstrated by the budget.

The descriptions of the children, methods of instruction and administrative procedures which have evolved throughout this program have been reported in detail in order to present to all Special Educators a model from which programs for children with handicaps other than visual may derive. The staff of the Allegheny Intermediate Unit No. 3 Title VI project, and the consultants to the project, trust that this report will prove useful and welcome any further questions about the program which may arise.

APPENDIX

JOINT REFERRAL FOR THE SERVICES OF
PENNSYLVANIA ASSOCIATION FOR THE BLIND

AND

ALLEGHENY COUNTY SCHOOLS
EXCEPTIONAL CHILDREN'S PROGRAM

In order to help prevent early social and sensory deprivation in visually impaired children, the Pennsylvania Association for the Blind and Allegheny County Schools are suggesting that doctors refer their visually limited patients as soon after birth as possible. For the purpose of our program, visually impaired children are those who because of the type and degree of visual impairment may benefit from sensory stimulation and educational techniques before school age or who may need special modifications in curriculum, materials and methods of instruction when they go to school.

Please send both copies of this form to Allegheny County Schools in the envelope provided.

Name of child _____

Birthdate _____

Name of parent or guardian _____

Address _____

_____

_____

Phone _____

Diagnosis: _____

_____

_____

_____

ALLEGHENY COUNTY SCHOOLS VISION PROGRAM
Eastern Area School
2430-R Greensburg Pike
Pittsburgh, Pennsylvania 15221

REFERRAL FORM

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ FATHER'S NAME: _____

_____ PHONE NO.: _____

SCHOOL DISTRICT: _____ SCHOOL: _____

DATE OF REFERRAL: _____

V.A.: O.D. _____ O.S. _____

DOCTOR: _____

DIAGNOSIS: _____

_____

_____

EVALUATION: _____

_____

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INFORMATION SHEET FOR PRESCHOOLS

NAME _____ PHONE _____

ADDRESS _____

_____

_____

DIRECTOR _____

NUMBER OF TEACHERS BA MA OTHER CERTIFIED

_____

CLASS SIZE _____

GROUP DESCRIPTION _____

HANDICAPPED _____

COST _____

SCHOLARSHIPS _____

PROGRAM

INFORMATION SHEET FOR RESIDENTIAL FACILITIES

NAME _____ PHONE _____

ADDRESS _____

_____

_____

DIRECTOR _____ SPECIAL PROGRAMS

AGENCY _____

SERVICES PROVIDED:

EDUCATIONAL _____

PSYCHIATRIC _____

THERAPUTIC _____

STAFF RATIO _____

QUALIFICATIONS _____

_____

REFERRAL PROCEDURE _____

_____

A STATEMENT BY
DAVID M. HILES, M.D., PEDIATRIC OPHTHALMOLOGIST

The ophthalmologist is often disturbed by apparent lack of visual progress in growth and development that occurs in young patients. These children often are physically, socially, emotionally and educationally slower than their sighted peers. Heretofore, we did not have the necessary educational personnel to develop programs to overcome these defects.

Recent changes have occurred in special education for the visually handicapped children in the Pittsburgh area. New ideas have been developed to encourage and enhance growth and development in younger and younger children who are handicapped. To implement these techniques requires a specialized preschool educator trained in education of the visually handicapped children. For the past 18 months such a program has been developed and is in force in Allegheny County.

The program deals with the techniques of physical stimulation of young children, stimulation of low vision to useful levels, develops visual concepts in low visioned children, enhances peer relationships and trains increased mobility techniques in younger ages. These areas of training greatly enhance the optical, medical and surgical treatment by developing the skills that hopefully the ophthalmologist has made physically available. This interdisciplinary approach is to be encouraged in the rehabilitation of many more patients than we had previously realized.

The development of understanding, confidence, motivation, stimulation and education in the parents of the handicapped child is a second area of great importance. The continued support of these parents during the period that the child is undergoing treatment secondarily enhances their relationship with the ophthalmologist and also makes rehabilitation more meaningful to the ophthalmologist, the child and his parents.

COPY

February 23, 1972

Mrs. Gayle Park
6337 Jackson Street
Pittsburgh, Pennsylvania 15206

Dear Mrs. Park:

The close working relationship between your program and caseworkers from this agency has been most gratifying. As caseworkers we work with the parents of multi-handicapped blind pre-schoolers in helping them to resolve emotional problems relative to their handicapped children. We believe this combination of the educator and the caseworker has affected the progress shown by both the children and their parents.

Sincerely,

(Miss) Margaret F. Gnade
Director, Welfare Services
Pittsburgh Association for the Blind, Inc.

MFG:clp

COPY

COPY

May 31, 1972

Dr. Edward P. Cibik, Jr.
Allegheny Intermediate Unit No. 3
Exceptional Children's Program
Jones Building
311 Ross Street
Pittsburgh, Pa. 15219

Dear Dr. Cibik:

The Developmental Clinic staff has been fortunate to have been able to collaborate with Mrs. Gayle Park in the management of several visually handicapped infants and preschool children under the Title VI ESEA project of which she is director.

I would like to express my enthusiasm for the philosophy of the program and my admiration for the techniques which are being employed in working with the children and their families. I am sure the program can be generalized to include multiply-handicapped children of a wide variety.

As Director of the Developmental Clinic, I would like to recommend that the program be continued if at all possible.

Sincerely yours,

Grace S. Gregg, M.D.
Director, Developmental Clinic
Children's Hospital of Pittsburgh

GSG/au

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May 18, 1972

Dr. Edward P. Cibik, Jr.
Director of Special Education
Allegheny Intermediate Unit 3
B. F. Jones Annex, 311 Ross Street
Pittsburgh, Pennsylvania 15219

Dear Dr. Cibik:

As you undoubtedly know, a meeting of the steering committee of the Title VI-A, E.S.E.A. project for pre-school visually handicapped children was held last Monday, May 15, 1972. Even though we have no pre-school classes in the Diocese of Pittsburgh, I was asked to represent the diocese since, in my capacity as psychologist for our schools, I do see some children of pre-school age.

Having learned of the project, I can foresee occasions arise when I might want to ask for the services that are now available since our services—of necessity—are limited. Hence I do endorse the program.

Sincerely,

Sister Helen T. Santay, C.D.P.
Psychologist

SHTS:ls

Copy to Mrs. Gayle Park

COPY

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DISSEMINATION

Three hundred copies of this report have been disseminated throughout Allegheny County, Pennsylvania, and the United States. Following is a breakdown of persons, agencies, and institutions who have received copies.

Project Staff Members	5
Psychologists, Supervisors of Allegheny Intermediate Unit	7
Board of Directors of Allegheny Intermediate Unit	14
Chief School Administrators in Allegheny County	46
Directors of All Intermediate Units in Pennsylvania	29
Supervisors of Vision Programs in All Intermediate Units	29
Cooperating Agencies	3
Steering Committee	8
Libraries and Information Services	8
Associations of Professional Workers and Agencies for the Blind	4
Organizations for Early Childhood Education	3
Federal Agencies	2
State Agencies	4
Schools for Blind Children	4
State Residential Institutions	5
Professional Preparation Institutions	23
Pennsylvania Association for the Blind Branches	30
Catholic Special Facilities in Pennsylvania	5
Easter Seal Society	4
United Cerebral Palsy	4
Medical Personnel	5
State and Federal Legislators	10
Interested Individuals	34